

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/19/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G001		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2006	
NAME OF PROVIDER OR SUPPLIER IDAHO STATE SCHOOL AND HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ELEVENTH AVE NORTH NAMPA, ID 83686			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during your complaint investigation and recertification survey.</p> <p>The surveyors conducting your survey were: Sherri Case, LSW, QMRP, Team Leader Michael Case, LSW, QMRP Lois Hollingsworth, R.N. Lea Stoltz, QMRP Nicole Wisenor, QMRP Monica Williams, QMRP</p> <p>Common abbreviations/words used in this report are:</p> <p>ABC - Antecedent, Behavior, Consequence ADHD - Attention Deficit Hyperactive Disorder AOD - Administrator on Duty BRF - Behavior Reporting Form BSP - Behavior Support Plan COPD - Chronic obstructive pulmonary disease CSU - Client Service Unit DOP - Destruction of Property HIS - Human Interaction System IDT - Interdisciplinary Team IST - Intervention Strategy Team h.s. - At bedtime HRC - Human Rights Committee LPN - Licensed Practical Nurse LWOP - Leave Without Permission NOS - Not Otherwise Specified OCD - Obsessive Compulsive Disorder OPFR - Nursing Notes PCP - Person Centered Plan PICA - Ingesting non-edible material PRN - As Needed PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Professional RN - Registered Nurse</p>			W 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 SIB - Self Injurious Behavior SER - Significant Event Report	W 000			
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined each recipient for whom payment was requested was not receiving active treatment as specified in 483.440. The findings include: 1. Refer to W195 - Condition of Participation for Active Treatment Services not met and related standard level deficiencies.	W 100			

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W 102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility's governing body failed to take actions that identified and resolved systematic problems of a serious and recurrent nature. As a result individuals' safety and active treatment services were negatively impacted. Findings include:</p> <p>1. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies. The facility was cited at W104 during an annual recertification survey dated 3/8/02, a complaint investigation on 4/24/03, a recertification survey on 8/1/03, a follow up survey on 5/5/04, and a recertification survey on 3/29/05.</p> <p>2. Refer to W122 - Condition of Participation: Client Protections and related standard level deficiencies including W127 as it relates to the facility's failure to ensure individuals were not subjected to abuse, neglect, or mistreatment, and parents/guardians were given the necessary information to provide informed consent. The facility was cited at W122 during an annual recertification survey dated 3/8/02, a follow up survey on 6/28/02, a complaint investigation on 4/24/03, and a recertification survey on 8/1/03.</p> <p>3. Refer to W195 - Condition of Participation:</p>	W 102			

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W 102	Continued From page 3 Active Treatment Services as it relates to the facility's failure to provide an aggressive, continuous active treatment program to promote the acquisition of skills necessary for individuals to function with as much independence and self-determination as possible. The facility was cited at W195 during an annual recertification survey dated 3/8/02, a follow up survey on 6/28/02, a recertification survey on 8/1/03, and a follow up survey on 5/5/04. 4. Refer to W266 - Condition of Participation: Client Behavior and Facility Practice as it relates to the facility's failure to ensure policies and individual programs were sufficiently developed, implemented, and monitored to meet individuals' behavioral needs. The facility was cited at W266 during an annual recertification survey dated 3/8/02, a follow up survey on 6/28/02, and a recertification survey on 8/1/03.	W 102			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for the individuals residing at the facility. This failure had the potential to negatively impact 91 of 91 individuals (Individuals #1 - #91) residing at the facility. Failure of the governing body to ensure these requirements	W 104			

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W 104	<p>Continued From page 4</p> <p>were met resulted in the facility's policies/procedures being inadequately developed, monitored, and implemented, the facility being found out of compliance with four (4) Conditions of Participation, and individuals being placed in serious and immediate jeopardy. The findings include:</p> <p>1. The facility's restraint policy (R.L.#1) effective, 8/18/00, stated "It shall be the responsibility of the Treatment Team to develop a comprehensive behavior modification program for any behavior that prompts the use of emergency physical, mechanical, or chemical restraints more than three times in a six month period unless the team determines and documents in the individual's program record that the precipitating conditions were transitory, not likely to be repeated..."</p> <p>However, the "Emergency use of Psychoactive Drugs Policy (R.L. #18), effective 1/15/93, stated "Any individual for whom emergency psychoactive drug usage is frequently necessary (more than four times per 30-day period) shall be referred to the Psychoactive Drug Review Committee for review. The policy did not include parameters for incorporating prn medications into a plan. When asked about the policy, the Acting Administrator stated on 6/15/06 at 2:10 p.m. the criteria in the R.L. #1 policy should be followed and R.L. #18 needed to be revised and combined with the other policy which addressed emergency restraint use. She further stated a draft of the revised policy had been completed.</p> <p>2. The behavioral intervention system included the use of the "Human Interaction System" (HIS). The facility's HIS manual, revised 2004, stated a</p>	W 104			

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W 104	<p>Continued From page 5</p> <p>trigger for an individual to be released from restraint was "if an hour as [sic] elapsed from the time the restraint was started. If the client has not been released during that time we are obligated to attempt to release them. Attempt does not mean letting go of the client and allowing them to get up to a standing position. What this means is we release our hold on only one part of the body, usually one arm, and then monitor the client to see how they act. If nothing happens, we may then release another arm, or maybe the legs. If however, they try to hurt others, injure him or herself or property, they have demonstrated they are not calm and we resume restraint for another period of time as indicated in the clients [sic] BMP or until another hour has passed.</p> <p>However, Individual #11's 1/20/06 restraint data documented he had been placed in a stand then sit restraint from 9:49 p.m. to 10:54 p.m., exceeding the 1 hour limit. No documentation of staff attempting to release Individual #11 when the restraint had lasted an hour could be found.</p> <p>When asked about the 1 hour time limit, the HIS instructor stated on 6/15/06 at 2:50 p.m., the hour time limit could be exceeded if the client was showing behavior that was indicative of them continuing to be a threat to themselves or others.</p> <p>The HIS manual was not clear in describing what circumstances would warrant the use of restraint which lasted over an hour without attempting to release the individual.</p> <p>3. A policy clarification memo dated, 8/18/00, was attached to the facility's restraint policy (R.L.#1). The memo stated "An escort is</p>	W 104			

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W 104	<p>Continued From page 6</p> <p>recorded when a client is moved from Point A to Point B with either a standing restraint or a carry. A carry will be recorded as an escort until we revise the form to capture this data separately." However, the facility's HIS manual, revised 2004, stated the "restraint technique to take a person who is combative from point A to point B" was called a "Two Person Transport Restraint" and "One Person Transport Restraint." The manual defined an escort as "not a restraint technique" but supporting or guiding an individual.</p> <p>The facility's policy clarification memo was not updated to reflect the revised HIS techniques.</p> <p>4. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to providing sufficient information to parents/guardians to ensure informed consent. The facility was cited at W124 during the annual recertification survey dated 8/1/03.</p> <p>5. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the spending decisions of Individuals' funds. The facility was cited at W126 during the annual recertification surveys on 5/22/01, 3/8/02, 8/1/03 and 3/29/05.</p> <p>6. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the facility's failure to ensure individuals were not subjected to abuse, neglect, and/or mistreatment. The facility was cited at W127 during the annual recertification survey on 3/8/02</p>	W 104			

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W 104	<p>Continued From page 7</p> <p>and a follow up survey on 6/28/02.</p> <p>7. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to policies and procedures to prevent abuse, neglect, and mistreatment were adequately developed, implemented, and monitored. The facility was previously cited at W149 during a complaint investigation on 4/24/03, a recertification survey on 8/1/03, a follow up survey on 5/5/04, a follow up survey on 8/26/04, and a recertification survey on 3/29/05.</p> <p>8. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure all allegations of abuse, neglect, mistreatment, and injuries of unknown origin were investigated. The facility was cited at W154 during a recertification survey on 3/8/02, a complaint investigation on 4/24/03, a recertification survey on 8/1/03, a complaint investigation on 11/1/04, a follow up survey on 5/5/04, and a complaint investigation on 3/10/06.</p> <p>9. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure individuals' services were sufficiently monitored and coordinated by the QMRP. The facility was cited at W159 during a complaint investigation on 4/24/03, a recertification survey on 8/1/03, a follow up survey on 5/5/04, a follow up survey on 8/26/04, a recertification survey on 8/27/04, and a recertification survey on 3/29/05.</p>	W 104			

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W 104	<p>Continued From page 8</p> <p>10. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to providing behavioral services to individuals. The facility was cited at W214 during the recertification survey dated 3/29/05.</p> <p>11. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to ensuring specific objectives were based on the identified needs of individuals. The facility was cited at W227 during the annual recertification surveys on 3/8/02 and 8/1/03, and a follow up survey on 5/5/04.</p> <p>12. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to ensuring program implementation plans included sufficient direction to staff. The facility was cited at W234 during the annual recertification survey on 8/1/03, the follow up surveys on 5/5/04 and 8/26/04, and the annual recertification survey on 3/29/05.</p> <p>13. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to ensuring the type and frequency of data collected was adequate to assess individuals' progress toward desired objectives. The facility was cited at W237 during the annual recertification survey dated 8/1/03.</p> <p>14. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies</p>	W 104			

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W 104	<p>Continued From page 9</p> <p>related to the failure to ensure interventions described in PCP's were consistently and correctly implemented. The facility was cited at W249 during the annual recertification surveys dated 5/22/01 and 3/8/02, the follow up surveys dated 6/28/02 and 11/8/02, the annual recertification survey dated 8/1/03, the follow up surveys dated 5/5/04 and 8/26/04, and the annual recertification survey dated 3/29/05.</p> <p>15. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure active treatment schedules were individualized and contained sufficient information to direct staff. The facility was cited at W250 during the annual recertification survey on 8/1/03.</p> <p>16. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure accurate data was collected that was reflective of individuals' progress. The facility was cited at W252 during the annual recertification survey on 3/8/02, and the follow up surveys dated 6/28/02 and 11/8/02.</p> <p>17. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure PCPs were revised to accurately reflect current needs and functional changes for individuals. The facility was cited at W260 during the annual recertification survey dated 3/8/02, the follow up survey dated 6/28/03, and the annual recertification survey dated 3/29/05.</p>			W 104			

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W 104	<p>Continued From page 10</p> <p>18. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure the human rights committee was provided with sufficient review information prior to obtaining approval for restrictive techniques. The facility was cited at W262 during the annual recertification survey dated 3/8/02.</p> <p>19. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to ensuring the maladaptive behavior policy included all positive and intrusive behavior interventions on a hierarchy ranging from most positive to most intrusive. The facility was previously cited at W277 during a recertification survey on 3/8/02.</p> <p>20. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure that prior to the use of restrictive techniques, lesser restrictive interventions were tried and found to be ineffective. The facility was cited at W278 during the annual recertification survey dated 5/22/01, the annual recertification survey dated 3/8/02, the annual recertification survey dated 8/1/03, a complaint investigation on 11/1/04, and the annual recertification survey dated 3/29/05.</p> <p>21. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure all behavioral</p>			W 104			

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W 104	<p>Continued From page 11</p> <p>interventions were written into individuals' PCPs. The facility was cited at W289 during the annual recertification survey dated 5/22/01 and the annual recertification survey dated 3/8/02.</p> <p>22. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to the failure to ensure the use of physical restraints, as a behavioral intervention, were written into individuals' PCPs. The facility was cited at W295 during the annual recertification survey dated 3/8/02.</p> <p>23. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to plans to reduce the use of behavior modifying drugs. The facility was cited at W312 during the annual recertification survey dated 3/8/02 and the annual recertification survey dated 3/29/05.</p> <p>24. The governing body failed to provide sufficient operating direction over the facility to ensure continued correction of past deficiencies related to ensuring infection control procedures were followed. The facility was cited at W455 during the annual recertification survey dated 3/8/02.</p>	W 104			

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W 122	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, review of incident/accident reports, record review, and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect individuals. This resulted in individuals not being supervised as per their PCPs, an individual's personal funds being used for programmatic activities, insufficient policy definitions to prevent PICA, and a lack of corrective action taken to prevent the reoccurrence of incidents which negatively impacted the physical well being of individuals residing in the facility. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W124 as it relates to the facility's failure to ensure sufficient information was provided to parents/guardians on which to base consent decisions. 2. Refer to W127 as it relates to the facility's failure to ensure individuals were provided with sufficient staff supervision necessary to ensure their health and safety. 3. Refer to W126 as it relates to the facility's failure to ensure an individual's personal funds were not used for programmatic activities. 4. Refer to W149 as it relates to the facility's failure to adequately develop, implement, and monitor policies and procedures related to PICA requiring medical attention. 	W 122			

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W 124	<p>5. Refer to W154 as it relates to the facility's failure to ensure all alleged violations were thoroughly investigated.</p> <p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 5 of 8 individuals (Individuals # 13 - #16, and #19) whose consents were reviewed. This resulted in parents/guardian not receiving sufficient comprehensive information necessary to make fully informed treatment decisions. The findings include:</p> <p>1. On 5/15/06, the Clinical Director provided a memo related to Pine Group 1. The memo stated the following had occurred:</p> <p>8/05: The QMRP was on leave until she resigned on 11/2/05 and other professional staff were assisting to perform the QMRP responsibilities until a new QMRP was hired on 1/27/06.</p>			W 124			

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W 124	<p>Continued From page 14</p> <p>11/05: The adolescents were combined into one group. "The move of course did cause increased problems."</p> <p>12/2/05: The Pine Group 1 Clinician resigned. The Clinical Supervisor was assigned as the interim Clinician until a new Clinician could be hired on 3/6/06.</p> <p>Additionally, the individuals residing on the unit changed as some were discharged and some were admitted (i.e., Individuals #5 and #12 were admitted on 10/21/05 and 2/3/06 respectively), increasing the number of maladaptive behaviors and restraints on the unit.</p> <p>Individual #15's record included a written informed consent, signed by Individual #15's guardian, on 3/07/06. The attached BSP, dated 1/27/06, stated he was a 14 year old male with diagnoses which included bipolar disorder, hypomania vs. mixed with psychosis, attention deficit hyperactive disorder (ADHD) combined type, oppositional defiant disorder by history, learning disability not currently specified, nocturnal enuresis, and probably mild mental retardation. The BSP included objectives for assaults, DOP, LWOP, and bizarre speech. The "Functional Assessment" section of the plan stated he was "very sensitive to noise and chaos which can result in his becoming nervous, frustrated or anxious which leads to yelling at others and sometimes escalating into targeted behaviors like physical assault and LWOP."</p> <p>The assessment did not include information related to continuing changes in his peer group,</p>	W 124			

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W 124	<p>Continued From page 15</p> <p>the changes in his treatment team members, or what impacts those changes were having on Individual #15's behavior.</p> <p>Without updated assessment information in his BSP, reflecting environmental factors which potentially impacted his maladaptive behavior, the facility would not be able to ensure Individual #15's guardian was provided sufficient information necessary to give fully informed consent.</p> <p>2. Individual #14's BSP, dated 3/29/06, stated he was a 14 year old male. His BSP included objectives for assaults, self induced vomiting, destruction of property, and self harm. He required 1:1 staffing.</p> <p>His Psychoactive Drug Review notes, dated 12/16/05, stated "He has had an increase in assaults over the last three months for reasons that appear to relate to a change of environment, with change in his peer group specifically being an issue, and also recently a change of treatment staff...The treatment team recommends no medication changes while behavioral interventions are explored and instituted."</p> <p>However, his Psychoactive Drug Review notes, dated 3/10/06, stated "An anxiety observation checklist was performed with a score of 40, which shows a reasonably significant amount of anxiety symptoms. He has been vomiting frequently, which is self-induced, and staff feels that it is an expression of his anxiety symptoms...It seems that the anxiety symptoms are significant enough to warrant some exploration of treatment alternatives...Alteration of Clomipramine [Anafranil] with Lexapro would reduce the</p>	W 124			

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W 124	<p>Continued From page 16</p> <p>potential cardiotoxicity of his medication regimen...We discussed various benzodiazepine choices and Klonopin and Xanax XR seemed more desirable..." No documentation of discussion related to on-going peer group and treatment team staff changes could be found in his Psychoactive Drug Review notes.</p> <p>His written informed consent stated "I voluntarily give consent for the attached program..." The attached program was Individual #14's 3/29/06 BSP. The BSP stated the plan was being revised to "request consent for medication changes. Medication changes are being considered due to the concern over [Individual #14's] increased frequency of self-induced vomiting." His BSP also stated Anafranil would replace Lexapro and Xanax-XR would be started to better address issues of impulse control disorder (not otherwise specified) and Anxiety disorder (not otherwise specified) "as evidenced by assaults, self harm, and episodes of self induced vomiting due to anxiety." The plan further stated "This individual appears to continue to experience difficulty with processing his anxiety which results in increased frequencies of self-induced vomiting..." The "Functional Assessment" section of the plan stated "A major antecedent to [Individual #14's] behaviors, particularly assaults and vomiting, are scheduled and unscheduled visits with his family. [Individual #14] tends to become particularly agitated when he had contact with his biological mother, via telephone, or scheduled or unscheduled visits. Recently, [Individual #14's] mother had a child. She had visited somewhat regularly prior to the baby's birth. However, the number and length of her visits has decreased and become less predictable, and [Individual #14]</p>	W 124			

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W 124	<p>Continued From page 17</p> <p>appears to be affected by it. He becomes assaultive both prior to and after her visits..." The "Functional Assessment" section his BSP also stated many of his "assaults appear to be when he is feeling overwhelmed by his environment being too chaotic and/or he is intimidated by something that is going on in his environment, such as another peer being restrained or aggressive..." The assessment did not include information related to continuing changes in his peer group (Individual #12 being admitted on 2/3/06, increasing the number of maladaptive behaviors and restraints on the living unit) or the changes in his treatment team members.</p> <p>When asked about the functional assessment information included in Individual #14's BSP, the QMRP stated during an interview on 6/15/06 at 8:56 a.m., his mother had a baby a long time ago, before she came and the QMRP who had assisted on the unit stated he believed the functional assessment was moved as a block from the old document to the new one.</p> <p>Without updated assessment information in his BSP, reflecting environmental factors which potentially impacted his maladaptive behavior, the facility would not be able to ensure Individual #14's guardian was provided sufficient information necessary to give fully informed consent.</p> <p>3. Individual #16's record included a telephone consent, dated 5/17/06, for an "Annual update of BSP T-3." Individual #16's BSP T-3, updated 5/17/06, stated he was a 15 year old male. His BSP included objectives for assault, suicide threats, destruction of property, self injurious</p>	W 124			

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W 124	<p>Continued From page 18</p> <p>behavior, and leaving without permission. The plan stated his "behaviors of physical assaults continue, but with variable frequency. Suicide threats have increased significantly since the inception of the last program. Other behaviors of leaving without permission and self harm have also increased. Reports of psychotic behaviors (e.g., bizarre thoughts, auditory hallucinations) continue."</p> <p>a. The BSP stated stated he "had been on a slow taper off the Risperdal until September when he had an increase in symptoms and the taper was stopped at the current levels. The team will monitor and continue the taper if [Individual #16] is able to tolerate it. The next med to be challenged would be the Topamax." His BSP further stated he "knew he was going to court to discuss possible re-commitment to [the facility] and had hope that he would go home so his behaviors were very good in July and August [2005]. He was recommitted in September and the data reflects his disappointment and frustration." The plan included behavioral data reflective of physical assaults, LWOP, DOP, suicide threats, sexual misconduct, and self harm from 1/05 - 12/05. The plan was not updated to include current data and no data regarding his "psychotic behaviors (e.g., bizarre thoughts, auditory hallucinations)" was included in the plan.</p> <p>Without sufficient assessment information based on objective current data regarding Individual #16's maladaptive and psychotic behaviors, the facility would not be able to ensure Individual #16's guardian adequate information on which to base fully informed consent.</p>	W 124			

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W 124	<p>Continued From page 19</p> <p>b. His BSP included an objective to "have a T-score of 55 or less on the Conner's' [sic] Rating Scale (ADHD) subcategory tested quarterly for 6 months..." The data collection section of the plan stated the Rating Scale "will be administered every three months" and the "Depression Observation Checklist will be administered monthly..." No updated data/information related to the scales (quarterly score, average score, etc.) was available.</p> <p>Without sufficient assessment information based on objective current data regarding Individual #16's ADHD and Depression ratings, the facility would not be able to ensure Individual #16's guardian had adequate information on which to base fully informed consent.</p> <p>c. Individual #16's BSP included a medication plan which stated he received Risperdal 1 mg each morning and 2 mg each evening and Abilify 2.5 mg each morning. However, his PDR notes documented his medications had been changed as follows:</p> <ul style="list-style-type: none"> - 10/7/05: The PDR note stated his Risperdal was tapered from 6 mg a day down to 2 mg a day. - 12/16/06: The PDR note included a plan to increase his Abilify from 2.5 mg to 5 mg each morning and consider a further decrease of Risperdal in 3 months. <p>The BSP was not updated to reflect Individual #16's current medication doses.</p> <p>Without updated, comprehensive information, related to Individual #16's behavioral status and behavior modifying medications, the facility would</p>	W 124			

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W 124	<p>Continued From page 20</p> <p>not be able to ensure Individual #16's guardian received sufficient information necessary to give fully informed consent.</p> <p>4. Individual #13's BSP, updated 6/16/05, stated he was a 16 year old male whose diagnoses included impulse control disorder (not otherwise specified) paraphilias, and mild to moderate mental retardation. His BSP included objectives for physical assaults, sexual misconduct, invasion of space, and grooming related to sexual misconduct. He was re-admitted to the facility on 03/23/05.</p> <p>A "Telephone Informed Consent," dated 12/16/05, stated "Increase Seroquel up to 300mg q AM and 700mg q HS." Consent was received from Individual #13's mother. A "Written Informed Consent," dated 12/17/05, was attached to the plan and stated the following: "I voluntarily give consent for the attached program." The document further stated, "This program has been explained in witting" and was signed by Individual #13's mother.</p> <p>a. The attached BSP stated "This 05-21-05 update is to address [Individual #13's] grooming behaviors as well as staff instructions to assist [Individual #13] in better managing his grooming behaviors. The update on 6/16/05 is to include additional positive interventions such as anger management." The status section of the plan stated his first several weeks at the facility had been "relatively uneventful. Then [Individual #13] began to re-engage in some of his previously documented challenging behaviors to include: attempts to choke staff and assaults toward his peers, and making verbal threats towards staff</p>	W 124			

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W 124	<p>Continued From page 21</p> <p>and peers. Further, [Individual #13] began to display sexual grooming type behaviors and poor physical boundaries with his peers and staff. Based on his history at [the facility] and other community placements the team feels strongly that the low number of his targeted behaviors since admission reflect a 'Honeymoon period'. The treatment team anticipates an increase or reemergence of targeted behaviors."</p> <p>Individual #13's status section of his BSP was not updated when the 5/21/05 and 6/16/05 revisions were made to his BSP. Without assessment information regarding his current status, the facility would not be able to ensure Individual #13's guardian had adequate information on which to base fully informed consent.</p> <p>b. The data for targeted behaviors section of the plan stated "The Treatment Team is still collecting baseline data for [Individual #13's] targeted behaviors as he has only been at [the facility] for approximately one month. Since he arrived he has assaulted staff twice and reported to his counselor that he 'will hurt anyone who makes him mad'. He has also reported to his counselor that he often thinks about certain boys living on his unit in a sexual way and wonders what it would be like to 'have sex with them.' He has told his counselor that he masturbates successfully while thinking about these particular boys. [Individual #13] also reports to his counselor that he wonders what it would be like to have sex with other boys when he is out in the community [sic] On prior occasions, he had assaulted a school aid...which resulted in severe head and neck injuries. He also assaulted his teachers and one was injured. It takes at least 4</p>	W 124			

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W 124	<p>Continued From page 22</p> <p>people to restrain [Individual #13] due to his strength and the violence of his assaults. Based on the nature of his behaviors warranting readmission and [Individual #13's] historical data, it is believed that the components of this program represent the least restrictive intervention to ensure safety and protect [Individual #13] and others from harm. Below is historical data on [Individual #13's] targeted challenging behaviors prior to his discharge in 2003." However, the data table in the plan was identified as 2005 data. It was not clear whether the data was reflective of 2003 or 2005 data.</p> <p>Without sufficient assessment information based on objective current data regarding Individual #13's maladaptive behaviors, the facility would not be able to ensure Individual #13's guardian had adequate information on which to base fully informed consent.</p> <p>c. Individual #13's BSP stated he was receiving Trileptal 1200 mg each day and Seroquel 600 mg each day. However, Individual #13's PDR notes documented his medications had been increased as follows:</p> <p>10/14/05 - Seroquel was increased to 200 mg each morning and 600 mg each evening, for a total of 800 mg daily and Trileptal was increased to 600 mg each morning and 900 mg each evening, for a total of 1500 mg daily.</p> <p>Individual #13's medication changes were not reflected in his BSP. Without an updated behavioral status, data, and intervention information, it would not be possible for the facility to ensure the guardian received sufficient,</p>			W 124			

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W 124	<p>Continued From page 23</p> <p>comprehensive information necessary to give fully informed consent for Individual #13's restrictive behavior interventions.</p> <p>5. Individual #19 was a 25 year old female with diagnoses of bipolar disorder, posttraumatic stress disorder, mild mental retardation and borderline personality. She was admitted to the facility on 4/5/2206.</p> <p>Her BSP, dated 5/2/06, included objectives for anger outbursts defined as exhibiting two or more incidents of verbal threats, loud voice, self-report of anger, self-injurious behaviors, and destruction of property. A review of the OPFR notes documented she had received the following PRN medication for anger outbursts:</p> <p>4/12/06 - 6:40 p.m. Haldol 5 mg and Benadryl 50 mg. 4/21/06 - 1:58 p.m. Haldol 10 mg and Benadryl 100 mg 5/23/06 - 11:00 a.m. Haldol 10 mg and Benadryl 100 mg</p> <p>The temporary informed consent stated "The treatment team recommended continuation of psychotropic medications to help keep {Individual #19} stable." The consent did not include the names or doses of the medications. On 6/16/06 at 8:16 a.m., the QMRP stated the names of the medication and dosages should be included in the consent.</p> <p>The facility failed to ensure the informed consent contained sufficient information regarding Individual #19's PRN medication.</p>	W 124			

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W 126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure staff did not make financial decisions for the use of individual's funds for 1 of 10 individuals (Individual #6) whose financial record was reviewed. This resulted in expenditure of personal funds for program related materials. The findings include:</p> <p>1. Individual #6's PCP, dated 2/15/06, documented a 52 year old male diagnosed with profound mental retardation, pervasive developmental disorder, autism, and OCD.</p> <p>Individual #6's BSP, revised 3/23/06, stated he engaged in pica and the replacement behavior included reinforcing Individual #6 when he stayed busy at other tasks "(putting puzzles together)." Under the section titled Positive Replacement Behaviors, it stated "[Individual #6] enjoys putting puzzles together and staff should praise [Individual #6] for doing the activity. When [Individual #6] is just walking around staff can sometimes get [Individual #6] to sit down and put puzzles together by giving him a piece to the puzzle. If he goes to put the puzzle together he should be verbally praised by staff."</p> <p>Individual #6's financial records showed a check was cut from his personal account for the amount of \$199.90. A completed order form, addressed</p>	W 126			

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W 126	Continued From page 25 to a catalog company and dated 9/12/05, showed the money was used to purchase puzzles. An invoice from the catalog company, dated 10/5/05, showed some of the puzzles had been discontinued and \$52.93 was returned to the facility. On 10/26/05, the \$52.93 was credited to Individual #6's personal account. The total cost of the puzzles, paid by Individual #6, was \$146.97. During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated puzzles were part of Individual #6's BSP and he should not have paid for them. The facility failed to ensure Individual #6's personal funds were not used for programmatic activities.	W 126			
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to provide sufficient supervision, monitoring, and intervention necessary to ensure the health, welfare and safety of individuals. This failure directly impacted 10 of 13 individuals (Individuals #5, #8, and #11- #18) whose SERs and Behavior Support Plans were reviewed. The lack of	W 127			

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W 127	<p>Continued From page 26</p> <p>sufficient staff supervision and intervention placed the individuals in serious and immediate jeopardy. The findings include:</p> <p>1. During an observation on 5/15/06 at 3:00 p.m., direct care staff, working with Pine Group 1 were asked about the needs of the individuals on the unit. At that time staff stated there were 8 individuals on the unit including Individuals #12 and #14 who required 1:1 staff. Individuals #5, #11 - #17 BSP's stated they had the following behavioral concerns:</p> <p>- Individual #5's BSP, dated 4/6/06, stated he was a 13 year old male who had a history of psychiatric hospitalizations and foster care placements due to battery, fire setting, theft, inappropriate sexual behaviors toward younger children and staff, and cruelty to animals. His BSP included objectives for physical assaults, invasion of personal space, sexual misconduct, anger outbursts, leaving without permission, and destruction of property.</p> <p>- Individual #11's BSP, revised 6/27/05, stated he was a 12 year old male. His BSP included objectives to reduce assaults, destruction of property, leaving without permission, and attempts to leave without permission.</p> <p>- Individual #12's BSP, revised 3/17/06, stated he was a 12 year old male. His BSP included objectives for physical assaults, psychotic behavior, destruction of property, and skin picking. His 4/21/06 "Inappropriate climbing behavior" program stated "Due tot the potential for harm caused by [Individual #12's] inappropriate climbing behavior he will be on</p>	W 127			

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W 127	<p>Continued From page 27</p> <p>enhanced 1-on-1 supervision, at arm's length anytime he is not in his room or the restroom."</p> <p>- Individual #13's BSP, updated 6/16/05, stated he was a 16 year old male who had a "long history of serious assaultive behaviors (both physical and sexual). His BSP included objectives for physical assaults, sexual misconduct, invasion of space, and grooming behaviors with sexual intent.</p> <p>- Individual #14's BSP, dated 3/29/06, stated he was a 14 year old male. His BSP included objectives for assaults, self induced vomiting, destruction of property, and self harm. He required 1:1 staffing.</p> <p>- Individual #15's BSP, dated 1/27/06, stated he was a 14 year old male. His BSP included objectives for assault, destruction of property, leaving without permission, and bizarre speech.</p> <p>- Individual #16's BSP, updated 5/17/06, stated he was a 15 year old male. His BSP included objectives for assault, suicide threats, destruction of property, self injurious behavior, and leaving without permission.</p> <p>- Individual #17's BSP, updated 5/18/05, stated he was a 13 year old male. His BSP included objectives for assaults, leaving without permission, obsessive episodes, and destruction of property. The data only section of the BSP included invasion of personal space and sexual misconduct.</p> <p>During an observation on Pine Group 1, on 5/15/06 at 7:10 p.m., Individual #13 was observed</p>	W 127			

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W 127	<p>Continued From page 28</p> <p>cleaning counter-tops in the kitchen and dining areas. At 7:30 p.m., a staff was asked what level of supervision Individual #13 required. The staff supervising Individual #13 stated line of sight was being maintained because Individual #13 was working with chemicals. At 7:35 p.m., the staff answered a phone call at the desk, leaving Individual #13 unsupervised in the kitchen with cleaning chemicals. At 7:38 p.m., the staff took a piece of paper to the desk, leaving Individual #13 unloading the dishwasher, unsupervised in the kitchen with cleaning chemicals. At 7:40 p.m., the staff took a soda can and piece of paper to the desk, leaving Individual #13 unsupervised in the kitchen with cleaning chemicals. On all three occasions, the position of the staff person in relation to the position of Individual #13 prevented line of sight supervision.</p> <p>Individual #13's Behavior Support Program, updated 6/16/05, stated his level of aggression "has warranted intense supervision and strict programming." The plan instructed staff to have Individual #13 "within total line of sight when he is awake" and "staff will not help other staff with duties that require them to give up the line of sight."</p> <p>During observation on 5/15/06 at 7:10 p.m., Individual's #5 and #16 were noted to be in Individual #16's bedroom; Individual #5 was playing video games and Individual #16 was working on/building bicycles. At 7:15 p.m., the unit Clinician was standing at the bedroom door, holding the door open to provide line of sight supervision to Individual's #5 and #16. The unit Clinician informed the surveyor at that time, line of sight was required whenever two individuals</p>	W 127			

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W 127	<p>Continued From page 29</p> <p>were in the same bedroom. At 7:45 p.m., the clinician left and a direct care staff resumed line of site supervision of the two individuals. At 7:50 p.m., the staff providing line of sight supervision received a radio call requesting assistance at the "car wash." The staff walked down the hall allowing the door to close with Individual's #5 and #16 in the bedroom. When the staff reached the end of the hallway, he was stopped by another staff. The second staff stated the individuals in the bedroom could not be left unsupervised for any period of time. After a brief discussion, the staff returned to supervising Individuals #5 and #16.</p> <p>The facility's Policy R.L. #25, Effective Date January 18, 2005, stated "Neglect is the failure to provide goods and services (including supervision) necessary to avoid physical or psychological harm and/or in such a manner as to jeopardize the life, health and safety of the individual." On 5/16/06 at 3:15 p.m., the Clinical Director was informed about the above mentioned incidents and asked whether or not the incidents, (when the staff broke line of sight to place items on the desk) rose to the level of neglect due to the incidents being brief and no one else (i.e. other individuals) being in the kitchen. The Clinical Director stated he would err on the side of caution and report the incidents. When asked if the facility had a reporting system in place to ensure supervisory staff were made aware of staff breaking line of sight if it did not rise to the level of neglect, the Clinical Director stated no. A subsequent investigation was conducted regarding all 3 of the above mentioned incidents brought to the attention of the facility by the surveyors, and neglect was substantiated.</p>	W 127			

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W 127	<p>Continued From page 30</p> <p>The facility's Significant Event Reports (SER) from 2/06 - 5/06 were reviewed and documented the following incidents which occurred on Pine Group 1:</p> <p>a. SER #06-244 stated on 2/21/06 at 5:25 p.m., Individual #11 left the unit "for less than 10 seconds before he was observed by [staff from another unit]. Staff were observing 2 clients in the TV room, one client in the kitchen, one client on 1:1, 3 clients in day hall with staff supervisor completing paperwork." Attached to the SER was a Behavioral Reporting Form, dated 2/21/06 at 5:25 p.m., which stated "Client (Individual #11) left unit without staff observing. Client (Individual #11) was observed in hallway by [staff from another unit]. Client (Individual #11) started out bldg. (building) door." The Behavioral Reporting Form also showed that Individual #11 left the unit without permission at 4:00 p.m., 4:25 p.m., 4:33 p.m., and at 5:30 p.m. The attached Administrator/QMRP narrative on the incident, dated 2/21/06 stated "This was a staff error and appropriate personnel action will be taken with staff involved. All other staff have been reminded that to make sure make sure [sic] to know where all clients are all of the time."</p> <p>When asked about the incident, the QMRP stated during an interview on 5/22/06 at 11:14 a.m., staff were retrained in response to the incident. No documentation of the "appropriate personnel action" referenced above was evident. When asked if the event rose to the level of neglect, the QMRP stated on 5/22/06 12:13 p.m. the definition of neglect was broad and she was unsure whether or not the incident would be interpreted</p>			W 127			

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W 127	<p>Continued From page 31</p> <p>as neglect because he was only out of sight for 10 seconds therefore it was not necessarily neglect.</p> <p>b. SER #06-311 stated on 3/6/06 at 6:25 p.m., Individual #15 was in a restraint when he was assaulted by Individual #14. The report stated "new staff did not know to stay by him (Individual #14) at all times. Also a lot of commotion in the Day Hall." The report documented Individual #15 sustained a small red area under his left eye from the altercation with Individual #14. The attached Administrator/QMRP narrative on the incident, dated 3/10/06 stated "This incident was caused due to a staff error. It was discussed in the behavior meeting how to position the body to prevent assault opportunities and proper supervision that is required with this peer."</p> <p>When asked about the incident, the QMRP stated during an interview on 5/22/06 at 11:14 a.m., staff had been retrained at the behavior meetings. The 3/30/06 Behavior Meeting minutes were reviewed. The minutes stated "Know where all clients are at all times." The minutes did not include which staff were present at the meeting.</p> <p>c. SER #06-468 stated on 4/2/06 at 3:30 p.m., Individual #11 had left the unit without staff's permission or knowledge. The attached Administrator/QMRP narrative, dated 4/10/06, stated "Staff observed [Individual #11] outside after 3 minutes and prompted him to return. [Individual #11] was compliant with staff's request. [Individual #11] was checked by the nurse and no injury was found. This was a staff error and appropriate personnel action will be taken with staff involved. All other staff have</p>	W 127			

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W 127	<p>Continued From page 32</p> <p>been retrained to make sure and know where all of the clients are at all times."</p> <p>The 4/6/06 Behavior Meeting minutes were reviewed. The minutes stated "Remember body positioning g [sic] to protect clients" The minutes did not include which staff were present at the meeting.</p> <p>When asked about the incident, the QMRP stated during an interview on 5/22/06 at 12:05 p.m., she was unsure whether or not the incident should be reported as neglect. When the Clinician was asked at 12:06 p.m., he stated in his opinion, he would report unless there were extenuating circumstances and those circumstances would be documented in the BRF.</p> <p>d. SER # 06-479 stated on 4/5/06 at 10:57 a.m., Individual #17 was involved in a client to client assault. The attached behavior reporting form, dated 4/5/06 stated in the antecedent section Individual #14 "just returned from Dr. appt. cued to put coat on to go to school." The behavior section stated "slapped [Individual # 17] in the face." The consequence section stated "redirected - separated both." The attached supplemental investigation form, dated 4/5/06 stated "[Individual #14] returned from Dr. apt. [staff] qed [sic] time for school. [Staff] assisted [Individual #14] in adorning coat after which [Individual #14] punched [Individual #17] in right cheek." The attached Administrator/QMRP narrative on the incident, dated 4/14/06, stated the "incident was caused due to a staff error. It was discussed in the behavior meeting how to position the body to prevent assault opportunities and proper supervision that is required with this</p>	W 127			

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W 127	<p>Continued From page 33</p> <p>peer."</p> <p>When asked about the incident, the QMRP stated during an interview on 5/22/06 at 11:14 a.m., staff had been retrained at the behavior meetings. The 4/6/06 Behavior Meeting minutes were reviewed. The minutes stated "Remember body positioning g [sic] to protect clients." The minutes did not include which staff were present at the meeting.</p> <p>e. SER #06-519 stated on 4/12/06 at 12:05 p.m., Individual #17 was involved in a client to client assault. The attached behavior reporting form, dated 4/12/06 stated, Individual #14 was encouraged to "go to lunch. On the way to the kitchen [Individual #14] slapped [Individual #17] in the face then slapped staff that was blocking, grabbed glasses off staff. Options for quiet time [Individual #14] chose his room." The behavior section of the form stated "Slapped [Individual #17] in face. Slapped staff in face. Grabbed glasses off of staff." The consequence section of the form stated "Blocked and redirected. [Individual #14] ran to his room to quiet down." The attached supplemental investigation form, dated 4/12/06 stated "Individual #14 was 1:1 with a new, not so preferred staff...on the way to kitchen ran up to [Individual #17] to assault - staff ran after but could not stop him in time." However, the attached Administrator/QMRP narrative on the incident, dated 4/21/06, stated the "incident was a staff error. The new staff was informally trained by co-workers on how to anticipate, body position and re-direct the peer before the assault occurs."</p> <p>When asked about the incident, the QMRP stated</p>	W 127			

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W 127	<p>Continued From page 34</p> <p>during an interview on 5/22/06 at 11:14 a.m., the new staff had been through new employee orientation and was probably a permanent staff on the unit. She stated the leadworker had trained the new staff on the behavior plan, however, it was not documented to her knowledge.</p> <p>f. SER #06-560, stated on 4/18/06 at 5:20 p.m., Individual #15 "flung" a belt at Individual #12's legs. Individual #12 "got mad and jumped off the brick wall on top of [Individual #15] and bit him on the back of the neck. The report documented Individual #15 sustained redness to his upper neck and left occipital area. Attached to the SER was a Supplemental Investigation Form, dated 4/18/06 at 5:20 p.m., which stated two staff were off the unit following individuals towards the laundry area. "[Individual #12] had just come down from roof of [the building]. [Individual #15] had a belt for his pants in his hand. [Individual #15] was swinging belt around, towards [Individual #12's] legs. [Individual #12] jumped from the concrete wall on to [Individual #15] and bit him behind the left ear." The attached Administrator/QMRP narrative on the incident, dated 4/26/06 stated "This incident was caused due to a staff error. The appropriate personnel action will be taken. Staff will also discuss the inappropriate interactions between these two clients and the interventions that are needed to decrease their assaults on one another."</p> <p>When asked about the incident, the QMRP stated during an interview on 5/22/06 at 11:14 a.m., staff had been retrained at the behavior meetings. The behavior meeting notes, dated 4/27/06 stated "[Individual #12] 1:1 have helped. Staff is to keep</p>	W 127			

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W 127	<p>Continued From page 35</p> <p>[Individual #12 and #15] apart." The minutes did not include which staff were present at the meeting.</p> <p>g. SER #06-599 stated on 4/28/06 at 5:30 p.m., Individual #17 was involved in a client to client assault. The attached behavior reporting form, dated 4/28/06 stated in the antecedent section Individual #12 "was trying to get his shirt back from [Individual #17] and [Individual #17] was resisting so [Individual #12] grabbed [Individual #17's] lanyard around his neck and was choking him and made a rug burn like mark on his neck." The behavior section stated "choking see antecedent." The consequence section stated "separate clients." The attached supplemental investigation form, completed by the direct care staff, dated 4/28/06, stated Individual #12 "wanted to play with [Individual #17]. [Individual #17] had ahold of [Individual #12's] shirt. [Individual #12] tried to get shirt back [sic] and pulled on [Individual #17's] key holder." The attached Administrator/QMRP narrative on the incident, dated 5/8/06, stated the "incident was a staffing error. The appropriate personnel will be taken [sic]. The team is reviewing the increase interactions between [Individual #17] and this peer and the negative influence the peer is observed as having on [Individual #17] at this given time. Staff will be trained on verbally intervene [sic] with any negative behaviors that are observed between [Individual #17] and his peer."</p> <p>When asked about the incident, the QMRP stated during an interview on 5/22/06 at 11:14 a.m., Individual #12's 1:1 staff failed to intervene with Individual #12. She further stated Individual #12's</p>	W 127			

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W 127	<p>Continued From page 36</p> <p>staff was a borrowed staff and the system had been changed to have only core staff work with individuals designated as 1:1.</p> <p>h. SER #06-602 stated on 4/28/06 at 5:45 p.m., Individual #15 and Individual #12 were "trying to take dinner from each other. Began arguing then physically assaulted each other numerous times. Staff had to physically remove them off of each other." Attached to the SER was a Behavioral Reporting Form, dated 4/28/06 at 5:45 p.m., which stated "[Individual #12] jumped on [Individual #15]. Was choking peer and biting peer and punching peer in the face. Also attached to the SER was an investigation which stated "This incident was a staffing error. The peer is currently on 1:1 supervision and should have been closely supervised before and during the event. The appropriate personnel [sic] will be taken. Following this event the staff has been directed to provide the 1:1 supervision by only a core staff. These two peers continue to have multiple inappropriate interactions. The staff has been advised to closely monitor the two during interactions."</p> <p>A formal investigation of the 4/28/06 incident was conducted. The investigation was dated 5/3/06 and stated "While investigating a client to client assault the Lead Investigator discovered potential negligence in 1:1 staffing that resulted in client injury." The Narrative section within the investigation stated both QMRPs and a supervisor from the unit were interviewed about the incident. The investigation stated one QMRP "was not aware that there was an established protocol of not placing borrowed staff with 1:1 clients" and the second QMRP "was aware of the</p>			W 127			

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W 127	Continued From page 37 protocol of borrowed staff not being placed with 1:1 clients but stated that it has never been in writing." The investigation stated the supervisor stated she "was in her office at the time of the incident filling out an accident report from an injury she received from another client. She stated that [the unit], had been very chaotic because of behaviors displayed by two clients in particular. A number of staff were pulled away from their regular assignments to keep those two safe and other clients and staff safe ...She stated that she was not aware of any protocol that prohibited borrowed staff from working with 1:1 clients." The Interviews section within the investigation documented one staff stated "Just as he got there they (Individual #12 and Individual #15) had started fighting, mostly scratching and punching. He stepped in between them and told them to stop and he yelled for addition [sic] help ...the unit was very chaotic at the time. Another client [Individual #5] on the unit has been requiring staff to attend to him on a constant basis. A number of the staff had been pulled out of the unit to deal with this client. Prior to this incident there had been a number of restraints and a red alert to deal with [Individual #5] ...there was no staff with them when he came into the kitchen and the fight broke out." The investigation showed another staff stated "the shift started out OK then it became very busy and chaotic. [Individual #5] and [Individual #11] were having behaviors. Two staff were chasing after [Individual #11]. [Individual #5] was going around beating on stuff so three staff were following him around so it left just a couple of staff to work with the remaining clients." Under the Conclusion section of the investigation, it stated that under the facility's policy (titled Reporting and	W 127			

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W 127	<p>Continued From page 38</p> <p>Investigation of Potential Individual Abuse/Neglect from Staff and Other Non-Residents and dated 1/18/05), neglect did occur. There was no Administrative Review of Investigation attached to the investigation. Thus, it was unclear whether corrective action was taken by the facility.</p> <p>i. SER #06-610, stated on 4/29/06 at 8:05 p.m., Individual #15 tried to pour milk on Individual #12's stuffed cat. Individual #12 grabbed Individual #15's sweatshirt and bit him on the front of his face, under his left ear. Individual #15 sustained a 1½" by ¼" area of bruising and abrasion. Attached to the SER was an investigation which stated "This incident was a staff error as previously mentioned [Individual #12] is a one to one and should have been arm's length from the staff at the time of the incident. The appropriate personnel action has been given to the direct staff involved."</p> <p>A formal investigation of the 4/29/06 incident was conducted. The investigation was dated 5/3/06 and stated "While investigating a client to client assault the Lead Investigator discovered potential negligence in 1:1 staffing that resulted in client injury" The Narrative section within the investigation stated both QMRPs of the unit were interviewed about the incident. The investigation stated one QMRP "was not aware that there was an established protocol of not placing borrowed staff with 1:1 clients" and the second QMRP "was aware of the protocol of borrowed staff not being placed with 1:1 clients but stated that it has never been in writing." The Interviews section within the investigation showed the staff person, who was assigned as Individual #12's one to one, was interviewed and "He said it was very chaotic that</p>	W 127			

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W 127	<p>Continued From page 39</p> <p>day and a lot was going on, the boys were all acting up. We were trying to keep an eye on all of the boys. We were trying to keep male staff and the female staff separated because of the issues there, along with all the other stuff. It is kind of hard to be at two places at once.</p> <p>[Individual #12] runs around all the time all over the unit. It is hard to be stuck with him, because of his level of activity in and out of the building, it is very hard to keep on him." The investigation documented that the Lead Investigator asked the staff person if he had been briefed on Individual #12 before working with him to which the staff person replied "Not really. Nothing in great detail. I was told he was one to one. He is a fairly new client and I had never worked with him before. They told me he was one on one and can't climb on anything. That was basically it. It was new to me. I didn't know what he could or couldn't do."</p> <p>Under the Conclusion section of the investigation, it stated that under the facility's policy (titled Reporting and Investigation of Potential Individual Abuse/Neglect from Staff and Other Non-Residents and dated 1/18/05), neglect did occur. Attached to the investigation was an Administrative Review of Investigation, dated 5/14/06. The Administrative Review showed the following corrective action was to be implemented:</p> <ul style="list-style-type: none"> - "[The staff person assigned to Individual #12] to receive counseling re: 1:1 responsibilities." - "Improved systems for expectation of assignment of 1:1 staff (trained, unit staff)." - "Communication to [the QMRP] and [Unit] supervisors and lead workers re: expectations for 1:1 assignment of staff." - "Clarification of keeping male and female staff separated from an employee interview." 	W 127			

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W 127	<p>Continued From page 40</p> <p>It was unclear why the incidents between Individual #12 and Individual #15 (examples h and i) were investigated as neglect and the incident between Individual #12 and #17 (example g) was not investigated as neglect.</p> <p>j. SER #06-682 stated on 5/3/06 at 3:42 p.m., there was "lots of commotion on the unit and not enough staff to go around and take care of behaviors and monitor the boys as they came out of class." The attached Administrator/QMRP narrative on the incident, dated 5/11/06 stated "while staff were involved with several other clients exhibiting maladaptive behaviors; [Individual #17] left the unit, he wandered into several offices of the Pine 2 staff. A QMRP from another unit observed [Individual #17] unattended by a Pine 1 staff. The QMRP from another unit redirected [Individual #17] to the unit after several attempts to redirect. [Individual # 17] was left unattended by Pine 1 staff for approximately 7 minutes. [Individual #17] was checked by the nurse and no injury was found. In checking on this the staff was not in the appropriate zone at the time of the incident. I have talked with the staff about the importance of knowing where all our clients are all the time. This was a staff error in not remaining in the assigned area and appropriate personnel action will be taken with staff involved. I have reviewed with staff again that this is important in a crisis to keep track of all other clients as many will take this opportunity to elope."</p> <p>When asked about the incident the QMRP stated during an interview on 5/22/06 at 11:14 a.m., the staff did not call the other units for help when they</p>	W 127			

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W 127	<p>Continued From page 41</p> <p>were involved with individuals engaging in maladaptive behaviors. She stated staff needed to call for help so their assigned zones would not be left unattended.</p> <p>k. SER #06-683 stated on 5/3/06 at 3:46 p.m., Individual #11 left the area without staff's permission. The attached Administrator/QMRP narrative, dated 5/11/06, stated he left off the unit, "around the hall and started to run out the front door, he was out of staff's sight for approximately 1 minute or less. The staff on the unit was unaware that he had left. The RN and another staff spotted [Individual 11] as he was run [sic] out of the front door. They asked [Individual #11] to stop so they could talk with him, he complied. [Individual #11] discussed his frustration and processed with the staff, he then returned to the unit. [Individual #11] was checked by the nurse and no injury was found. The staff that was assigned to the kitchen area was not monitoring the area at the time of the incident, appropriate personnel action was taken.</p> <p>When asked about the incident the QMRP stated during an interview on 5/22/06 at 11:14 a.m., she had spoken to the staff involved, however, she had not documented the discussion.</p> <p>l. SER #06-636 stated on 5/3/06 at 7:-00 p.m., Individual #13 was involved in sexual misconduct. The attached behavior reporting form, dated 5/3/06 stated in the behavior section "[Individual 5] decided to go and sit in the van. [Individual #13] was outside of the van while staff were loading up the canoes onto the trailer. [Individual #13] went to the van to sit down when [Individual #5] came out of the van and told staff that</p>	W 127			

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W 127	Continued From page 42 [Individual #13] had asked him to pull his pants down so he could touch him in his private parts..." The behavior section of the report stated "Told [Individual #5] to pull his pants down so he could touch him." The consequence section of the form stated "Asked [Individual #13] what happened then [Individual #13] said he told you. Kept the 2 of them separated, [Individual #13] was upset that he told." The attached SER Team Review and Action Plan stated, "He had the opportunity to do so with no staff monitoring. Reports that he feel like he cannot control himself." The attached Administrator/QMRP narrative on the incident, dated 5/10/06 stated "...I investigated the event on the 4th of May by interviewing the staff involved with the incident. The staff reported that while they were lifting a canoe and loading it into the van for those 2 -3 seconds they did not have a visual on the clients and assume that is when [Individual #13] preceded the behavior. I informed the staff that the BRF was written in a way that the event read differently. The staff acknowledged the communication error on the BRF. Following the staff interview, I interviewed [Individual #5] about the event. He disclosed a matching story to the staff that while he was in the van alone [Individual #13] walked over and got into the van. While the staff were loading the canoe [Individual #13] asked [Individual #5] to pull his pants down, [Individual #5] explained that he told the peer that was inappropriate and explained that [Individual #13] then touched him and he got up and left to tell staff. I educated [Individual #5] about keeping himself self [sic] and that what the peer did was completely inappropriate. I also informed [Individual #5] that we the staff will do everything we can to keep him safe. [Individual #5] was cooperative through the interview." The	W 127			

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W 127	<p>Continued From page 43</p> <p>note further stated "The clinician [name] interviewed the peer. The peer confirmed the behavior in that he asked [Individual #5] to pull down his shorts and [Individual #5] refused, he then touched [Individual #5] over his clothes in the genital area. The peer then said that [Individual #5] left. The peer disclosed thoughts of shame and feelings like he cannot control his behavior. The clinician has just past through the HRC committee to implement a new intervention to assist with decreasing the peer's increased sexual thoughts and behaviors. Staff were informed to not allow the peer out of visual contact with another peer."</p> <p>When asked about the incident, the QMRP stated on 5/22/06 at 12:22 p.m., the incident rose to the level of neglect and she should have caught it. She stated she had verbally re-trained the staff involved, however, she had not documented the training with the staff.</p> <p>m. SER #06-655 stated on 5/7/06 at 2:40 p.m., Individual #17 was involved in a client to client assault. The attached behavior reporting form, dated 5/7/06 stated in the antecedent section, "[Individual #12] was teasing peer with toy. Peer attempted to take toy from Individual #12. Individual #12 took toy back and peer then assaulted him." The behavior section of the report stated "[Individual #12] hit peers hat off of head and at the same time hit peer in left eye." The consequence section of the form stated "Staff used verbal skills to calm [Individual #12]. He walked away from peer. Played with peer after 1/2 hour past." The attached supplemental investigation form, dated 5/67/06 stated "Peers were teasing each other with toys. [Individual</p>	W 127			

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W 127	<p>Continued From page 44</p> <p>#17] tried to take [Individual #12's] toy. [Individual #12] stopped him, [Individual #12] hit [Individual #17] in the arm, [Individual #17] retaliated and hit [Individual #12's] hat off and eye." The attached Administrator/QMRP narrative on the incident, dated 5/14/06 stated "This incident was a staffing error. The appropriate personnel [sic] were taken. The staff has been trained to closely monitor the two clients' behaviors with one another and to intervene during early negative interactions."</p> <p>When asked about the incident the QMRP stated during an interview on 5/22/06 at 11:14 a.m., she had given a verbal reminder to the staff member involved. However, she had not documented the verbal reminder with the staff member.</p> <p>The above mentioned "staff errors" resulted in the individuals on Pine Unit, Group 1 leaving without staffs' knowledge, being physically assaulted, and engaging in sexual misconduct. The cumulative effect of these deficient practices resulted in actual and potential negative impacts to the health, safety, and well being of the individuals residing on Pine, Group 1.</p> <p>2. Individual #18's PCP, dated 5/11/06, stated he was a 21 year old non-verbal male, diagnosed with severe mental retardation, possible autism, seizure disorder by history, and multiple scars secondary to self injurious behavior. Individual #18's PCP contained a "Behavior Support Program," dated 8/30/05, to instruct staff as to how to intervene when he engaged in the self-injurious behavior of hitting his head.</p> <p>His facility SERs, Behavioral Reporting Form,</p>	W 127			

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W 127	<p>Continued From page 45</p> <p>SER Team Review and Action Plans, and pertinent attached information were reviewed for the period 2/1/06 - 5/1/06, and documented the following dates/times of Individual #18 engaging in the self-injurious behavior of hitting himself in the head.</p> <p>- SER #06-238: The attached Behavioral Reporting form stated on 2/11/06, Individual #18 hit himself in the head at 7:45 a.m., 1:00 p.m., 1:15 p.m., and 1:30 p.m. One mark had been recorded for each of the aforementioned time periods. The SER Team Review and Action Plan stated Individual #18 had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." The SER said he had sustained "red skin at temple." A 2/11/06 "OPFR Charting" entry made by the LPN, at 1:30 p.m., said his "R (right) temple area is bright red." The LPN further stated he "is at table at this time, eating lunch but stop (sic) occasionally to hit his head." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits Individual #18 had inflicted to himself, nor for how long each occurrence of the behavior had continued. A form titled "Supplemental Investigation Form" said he was "offered time alone with soothing music" and "offered a bath." There was no corresponding data recorded/attached to reflect whether or not Individual #18 had taken part in either of those activities.</p> <p>- SER #06-210: The attached Behavioral Reporting form stated on 2/16/06, Individual #18 hit himself in the head at 7:45 a.m. and 8:00 a.m., resulting in "red skin." One mark had been recorded for each of the aforementioned time periods. The SER Team Review and Action Plan</p>	W 127			

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W 127	<p>Continued From page 46</p> <p>stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said he was "offered other functional activities, bath, walk, clean his room, and offered the opportunity to relax in a quiet place." There was no corresponding data recorded/attached to the SER to reflect which, if any, of those activities Individual #18 subsequently participated in.</p> <p>- SER #06-225: The attached Behavioral Reporting form stated on 2/19/06, Individual #18 hit himself in the head at 8:02 a.m., 8:17 a.m., 8:30 a.m., 11:43 a.m., and 1:15 p.m. One mark had been recorded for each of the aforementioned time periods. The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said he was "offered other activities, food, beverages, and a bath." There was no corresponding data recorded/attached to reflect which, if any, of those activities Individual #18 subsequently participated in. The check marks show redirection to activities was unsuccessful four of the five times.</p> <p>- SER #06-227: The attached Behavioral Reporting form stated on 2/19/06, Individual #18 hit himself in the head at 2:05 p.m. and 2:20 p.m.</p>	W 127			

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W 127	<p>Continued From page 47</p> <p>One mark had been recorded for each of the aforementioned time periods. The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said staff had redirected him "to a quiet area after showing no response to the initial hits to the head." An additional entry read, "redirected (him) to other activities, radio and time outside." There was no corresponding data recorded/attached to reflect which, if any, of those activities Individual #18 subsequently participated in.</p> <p>- SER #06-275: The attached Behavioral Reporting form stated on 2/27/06, Individual #18 hit himself in the head at 8:10 a.m. One mark had been recorded for the aforementioned time period. Information recorded on the form stated that he engaged in "high intensity hits to R temple." The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said he was "offered food, drink, and music but was not interested in those things."</p> <p>- SER #06-306: The attached Behavioral Reporting form stated on 3/5/06, Individual #18 hit himself in the head at 8:50 a.m. One mark had</p>	W 127			

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W 127	<p>Continued From page 48</p> <p>been recorded for the aforementioned time period. Information recorded on the form stated that he engaged in "high intensity hits to R temple." The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. A form titled "Supplemental Investigation Form" said staff "attempted to offer him a drink, applesauce and music." There was no corresponding data recorded/attached to reflect which, if any, of those activities Individual #18 subsequently participated in.</p> <p>- SER #06-335: The attached Behavioral Reporting form stated on 3/12/06, Individual #18 hit himself in the head at 8:10 p.m. One mark had been recorded for the aforementioned time period. Under the comment section of the form it stated, "hits to head." The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head," and that the "hits to head stopped within 15 minutes." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually occurred. A form titled "Supplemental Investigation Form" said "tried giving objects to trade to stop hitting of head, would not take."</p> <p>- SER #06-411: The attached Behavioral Reporting form stated on 3/23/06, Individual #18 hit himself in the head at 8:55 a.m. Initially 5 marks had been recorded for the aforementioned</p>	W 127			

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W 127	<p>Continued From page 49</p> <p>time period. The 5 marks had been circled and an error notation made, along with a single mark. Information recorded on the form stated that he engaged in "high intensity hits to R temple." It also said that he had been "offered several things to have, he didn't want anything." An "OPFR Charting" note made by the LPN stated, "his activity stopped without intervention." The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had actually inflicted to himself, nor for how long the behavior had continued.</p> <p>- SER #06-465: The attached Behavioral Reporting form stated on 4/1/06, Individual #18 hit himself in the head at 7:45 a.m., 8:00 a.m., 8:15 a.m., 8:30 a.m., and 8:45 a.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." It further stated he "was offered his headache medicine and he eventually took it and the behavior stopped by 9:00 a.m." Other than the offer of medication, the forms did not specify how staff had protected Individual #18 from harming himself.</p> <p>- SER #06-539: The attached Behavioral Reporting form stated on 4/14/06, Individual #18 hit himself in the head at 6:30 a.m. One mark had</p>	W 127			

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W 127	<p>Continued From page 50</p> <p>been recorded for the aforementioned time period. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." The Behavioral Reporting Form stated staff "turned on music - and gave him a cup of coffee, he soon stopped." None of the forms specified what, if any, protective measures staff had utilized to keep Individual #18 from harming himself.</p> <p>- SER #06-547: The attached Behavioral Reporting form stated on 4/16/06, Individual #18 hit himself in the head at 7:32 a.m. and 7:47 a.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." The Behavioral Reporting Form stated staff provided "non direct redirection, offered coffee, music and a walk, also offered Tylenol." There was no corresponding data recorded/attached to reflect which, if any, of those things Individual #18 subsequently took/engaged in. Conflicting information in "OPFR Charting" notes, written by the LPN, stated Individual #18 had begun "hitting himself in the Rt forehead" at 7:00 a.m. versus 7:32 a.m. None of the forms specified what, if any, protective measures staff had used to keep Individual #18 from harming himself.</p>	W 127			

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W 127	<p>Continued From page 51</p> <p>- SER #06-618: The attached Behavioral Reporting form stated on 5/1/06, Individual #18 hit himself in the head at 12:00 p.m. and 12:15 p.m. One mark had been recorded for each of the aforementioned time periods. From the data recorded on the Behavioral Reporting Form, it could not be determined how many hits he had inflicted to himself, nor for how long the behavior had actually continued. The SER Team Review and Action Plan stated he had inflicted "multiple hard hits to his head-hard enough to cause redness to his head." The Behavioral Reporting Form stated staff "took (him) on a walk to try and redirect, also offered drinks, and a variety for a snack, he continued to hit self on R temple." None of the forms specified what protective measures staff had used to keep Individual #18 from harming himself.</p> <p>Conflicting directions regarding the interventions staff were to utilize when Individual #18 hit himself in the head with "high intensity" were specified on page 27 of his 5/11/06 PCP: Direction #2 - if he begins to start hitting himself, staff should ignore the behavior showing no response to it, Direction #3 - intervention for high intensity hitting self is to include an attempt to redirect followed by physically intervening to block hitting self, and if it continues, use graduated HIS for protection from harm, Paragraph 2 of Direction #3 - ignore hits to head, showing no response to the behavior, if his hits to his head start causing red mark redirect him in a calm quiet calm voice.</p> <p>None of the above referenced behavior reporting forms contained clear, comprehensive information as to what had occurred prior to</p>	W 127			

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W 127	<p>Continued From page 52</p> <p>Individual #18 engaging in self-injurious behavior, nor did they provide specifics as to what staff had done to protect him from continuing to harm himself if initial cues/redirection were unsuccessful.</p> <p>Individual #18's QMRP and Clinician were interviewed on 5/22/06, from 11:10 a.m. - 11:55 a.m. and from 1:35 p.m. - 2:20 p.m. They were asked if the single marks recorded on the Behavioral Reporting Forms were to denote single intense hits Individual #18 made to his head. They stated they were recording episodes versus each individual hit, and that the number could vary from 1 on up.</p> <p>During the course of those interviews, the conflicting directions contained in Individual #18's behavior plan were acknowledged by both professionals. They stated that staff were not intervening by blocking Individual #18's initial and subsequent hits to his head, as it was felt that doing so had the potential to escalate the behavior. Information was requested from the professionals to support that blocking Individual #18's hits to his head was tried systematically and demonstrated to be ineffective. Behavior and restraint data graphs were provided that date, however, there was no way to tell what interventions, if any had actually been implemented for the time periods shown on the graphs.</p> <p>These incidents of intense hits to his head had the potential to negatively impact the physical well being of Individual #18.</p> <p>3. Individual #8 was an 18 year old male with</p>	W 127			

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W 127	<p>Continued From page 53</p> <p>diagnoses of moderate mental retardation, bipolar type 1, depression with psychosis, autism, ADHD, and PTSD.</p> <p>Individual #8's 12/2/05 PCP included a behavior support plan, updated 4/21/06, which described his challenging behaviors/symptoms as "physical assaults, psychotic behavior, insertion of objects and fingers, and lying on the floor." The program contained restrictive components of "1) HIS up to standard prone, 2) alterations made to medication criteria for increase/decreases, and 3) modifications to the instructions to staff for attempts/actual insertions." In addition, the plan included room searches for removal of all dangerous objects and the application of protective mitts to address Individual #8's rectal insertion behavior. Individual #8 was on "1:1 enhanced" staff supervision, with further instruction to maintain visual supervision at all times, including times he was sleeping. Staff were instructed in the plan to maintain visual contact with Individual #8's hands at all times, including during toileting and showering. His current medications were listed as Abilify (antipsychotic), Zyprexa (antipsychotic), Depakote ER (anticonvulsant), Prozac (antidepressant), and Topamax (anticonvulsant).</p> <p>Due to his history of inserting fingers/foreign objects into his rectum, a colonoscopy was conducted on 8/18/05. The report stated "{Individual #8} had a colonoscopy and large polyp (sic) found which was inflammatory in nature and secondary to insertions of foreign bodies and finger into rectum. This is a potentially dangerous situation which could lead to possible perforation of colon, increased polyp</p>	W 127			

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W 127	<p>Continued From page 54</p> <p>formation with risk of malignant change and rectal bleeding."</p> <p>The facility's Investigations were reviewed on 5/15/06 and 5/16/06. Investigation #A-06-307 contained information on an incident which occurred on 3/14/06, at which time Individual #8 had inserted a battery into his rectum, requiring x-ray for diagnosis and medical treatment. The investigation team determined neglect had occurred, and two staff involved had disciplinary action taken as a result.</p> <p>According to the 4/28/06 SER #06-607, reviewed on 5/18/06, Individual #8 had been left unattended during an outing at a local park. The form, under "Section D," had places for further information to be documented in the event of a LWOP or "left unattended", including times gone and location when found. No information was recorded on the form in regard to the incident, and the length of time Individual #8 was without enhanced 1:1 staff supervision.</p> <p>Attached to the SER were two pages of "charting" notes. The first entry was from the nurse on duty, dated 4/28/06 at 2:30 p.m., describing her observations and interactions with Individual #8 while at the park and upon return to the facility. The nurse reportedly saw him "within visual but alone" with a tackle box, holding a long orange object in his hand. A staff person was requested to check his pockets, which revealed no object. Individual #8 then "began to lean to the left (at the waist)" and continued to lean for the remainder of the trip. The nurse reported conducting a visual check in the bathroom at the park to check for signs of insertion, which Individual #8 reportedly</p>	W 127			

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W 127	<p>Continued From page 55</p> <p>denied doing. No signs were noted. Another staff's entry in the notes at 3:15 p.m. recorded further interactions with Individual #8. When questioned if and what he inserted, Individual #8 reportedly stated "a spoon". When asked when he did it, he stated "when he went to the bathroom." Individual #8 had continued to lean to the left side during the interview, and after his confession of inserting, the on-call physician was notified. An additional entry in the notes, at 3:50 p.m., indicated a hemoccult (test for blood in stool) had been done with negative results. No further documentation of the event was present, and whether or not Individual #8 had actually inserted a foreign body was not stated and could only be surmised by the hemoccult test entry.</p> <p>The QMRP was interviewed on 5/22/06 at 1:55 p.m. When asked what corrective action had occurred as a result of the incident in SER 06-607, she stated the unit staff person involved was re-trained in 1:1 protocol. Other staff involved in the incident were from another department, and she was unaware of any action taken. During a discussion on 5/22/06 at 5:30 p.m., the Clinical Director could not explain why the event described in SER #06-607 had not been formally investigated as a case of possible neglect.</p> <p>The facility failed to ensure Individual #8 received needed supervision as identified in his behavior support plan. Further, the facility failed to thoroughly investigate the incident and take appropriate corrective action.</p> <p>Note: The facility provided a plan of correction, dated 6/9/06, documenting revisions to the policy</p>	W 127			

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W 127	Continued From page 56 for significant event reports and training to all CSU staff regarding the revisions to the policy. The plan also documented the policy for enhanced supervision was revised to provide clearer definitions of the levels of supervision and all CSU staff received training on the revised policy. The plan stated all staff had received training on the current level of supervision for individuals for which they were responsible. An on-site visit was conducted on 6/12/06. Based on observation, record review, and staff interviews it was determined the immediate jeopardy had been abated.			W 127			
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review, and staff interviews, it was determined the facility failed to ensure policies and procedures to prevent and address pica requiring medical attention was adequately developed. This directly affected 1 of 1 individuals reviewed who engaged in pica behavior (Individual #6), and had the potential to affect all individuals residing at the facility who engaged in pica. The findings include:</p> <p>1. The facility's policy, titled Significant Event and Client-to-Client Assault and Self-Injurious Behavior Reporting (R.L. #22), was dated 1/9/06. Under the section titled Definitions, it defined Pica</p>			W 149			

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W 149	<p>Continued From page 57</p> <p>Requiring Medical Intervention as "Ingestion of non-edible material that results in a call to the Poison Control Center or other medical intervention." Under the section titled Procedure, it stated any staff that witnessed or received report of an event that met the definition were to take immediate action to protect the individual(s), notify the charge person, complete a Significant Event Report (SER), and give the SER to the nurse within one hour of the event.</p> <p>Individual #6's PCP, dated 2/15/06, documented a 52 year old male diagnosed with profound mental retardation, pervasive developmental disorder, autism, OCD, COPD, and was a Hepatitis B carrier. His BSP, revised 3/23/06, stated he engaged in pica behavior. His nursing notes, dated 10/12/05 - 5/21/06, documented multiple incidents of pica which included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 10/13/05: "DDT (staff) reports PICA (whole cigarette) on a walk." - 10/26/05: "DCS (staff) reports while transporting from van to bldg. that he reached down and grabbed bark from the flower bed and ate it." - 11/2/05: "DCS (staff) reports that client drank an estimated 2 - 3 oz. of baby shampoo." - 12/9/05: "DCS (staff) report client swallowed a penny." - 12/17/05: "[Individual #6] ate a small sample pkg. of parmesan cheese with the wrap." -12/23/05: "DCS (staff) reported [Individual #6] at 	W 149			

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W 149	<p>Continued From page 58</p> <p>[sic] a bandaid that was on the floor."</p> <p>- 3/1/06: Client sent to [hospital] found multiple (more than 12) staples already used in the colon. One small piece of paper clip present per doctor ..."</p> <p>- 3/12/06: "[Individual #6] found a poker chip et (and) tried to swallow it. He was able to cough it up after 3 attempts. He was able to breathe through these coughing episodes, but was in distress."</p> <p>- 3/31/06: "DCS (staff) reported that [Individual #6] ate a rubber band ..."</p> <p>- 4/6/06: "DCS (staff) report client drank approx. 1 - 2 oz. of liquid spray hair gel. Poison Control called ..."</p> <p>- 5/21/06: "[Individual #6] bit the end off from a pen (pea) size approx. size."</p> <p>Corresponding SERs could not be found for the above mentioned incidents. During an interview with the QMRP on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP reported nursing staff made the decision as to whether medical attention was needed and usually followed the policy. During the interview, the LPN was asked about reporting requirements for pica. The LPN stated all incidents of pica were reported to nursing staff. Individual #6's Monthly Nursing Reviews, dated 9/05 - 4/06, showed the following monthly incidents of pica: 9/05: 2 10/05: 7 (cigarette, cigarette butts, and bark) 11/05: 3 (baby shampoo, cigarette butt, CalStat</p>	W 149			

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W 149	<p>Continued From page 59</p> <p>antiseptic hand-rub) 12/05: 3 (penny, plastic food wrapper, and a bandaid) 1/06: 0 2/06: 2 (metal eraser tip and a Kool-Aid pkg.) 3/06: 0 (found staples and paper clip "adhered to upper left abd area.") 4/06: 3 (liquid spray hair gel, candy wrapper, and paper from a notebook)</p> <p>However, Individual #6's behavior data for pica, dated 9/05 - 4/06, showed the following monthly incidents of pica: 9/05: 4 10/05: 7 11/05: 8 12/05: 17 1/06: 16 2/06: 17 3/06: 29 4/06: 10</p> <p>An interview was conducted with the Acting Administrator on 6/15/06 from 1:30 - 2:45 p.m. When asked about the definition of Pica Requiring Medical Intervention contained within the policy, the Acting Administrator concurred the definition was unclear.</p> <p>The facility failed to ensure policies and procedures to prevent and address pica were specific enough to direct staff as to when and to whom they were report incidents of pica.</p>	W 149			

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W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on review of investigation reports, review of significant event reports, and staff interviews it was determined the facility failed to ensure all allegations of abuse, neglect, mistreatment, and injuries of unknown origin were investigated for 5 of 91 individuals (Individuals #20, 25, 30, 59 and 92) residing in the facility. This resulted in an absence of appropriate investigation and follow up to the incidents. The findings include:</p> <p>1. An Investigation Report Form, dated 1/23/06, stated an RN "reported that [Individual #92] was inappropriately transported to hospital. She was taken by van instead of ambulance. She also stated that [Individual #92] was suffering from Hypoxia and needed oxygen. There [sic] documentation was not clear if she was given oxygen. Also [the staff's name] the RN/AOD had made a comment that she was old anyway and did not need the ambulance." Individual #92 passed away the evening of 1/21/06.</p> <p>A written statement from a direct care staff, dated 1/23/06, documented that on 1/21/06 a staff person went into [Individual #92's] bedroom to take vital signs. "I started off taking her temp looking at her face, I saw that her tongue was extremely blue so I put the sats monitor on her and called [a second staff person] into the room. [The second staff person] saw [a third staff person] come around the corner and told her what was going on. Her [Individual #92's] sats</p>			W 154			

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W 154	<p>Continued From page 61</p> <p>were at 75 but every time she moved they would go down. Me and [the second staff person] lifted [Individual #92's] bed up repositioned her and still the sats where [sic] low. [The third staff person] called the [RN] AOD and told him what we found. On arrival [the RN] walked into the room where me, [a staff] and [Individual #92] where [sic] and standing by her bed siad [sic] yep that looks like [Individual #92] in a very aggressive manner and then he siad [sic] well what do you guys see that I don't? and I asked him to look at her tongue and sats monitor. He continued in the same voice saying the machine was inaccurate and to take the pulse on her wrist. I tried to explain that [the third staff person] had just taken it with a stethoscope [sic] apicol [sic], he wouldn't listen and asked to continue which I did. It was accurate with what was on the sats monitor. When he was at the end of [Individual #92's] bed just about to walk back out to the Nurse Station he siad [sic] in the same tone as before I don't know what you expect she's old! and walked out. This whole time he didn't ask for any oxygen or call for an ambulance. I found this problem about 2:20 and she left for the hospital in the state van not an ambulance about 3:30 with no oxygen and [the RN] only wanted one staff to go with her."</p> <p>Individual #92's nursing notes, dated 1/21/06 at 2:45 p.m., documented the LPN assessed her at 2:35 p.m. and she was diaphoretic and pale. The nursing entry stated the following: "U/S = 92/50, 101 irreg. Resp 28 - 48, T = 99.8, SATS 68% - 85% - 79%, diaphoretic, lips - tongue bluish grey. Nail beds blue. BG's 261 @ 1400 now 241. Lungs CTA, ABS x 4 quads no noted tenderness. Notify RNC."</p>	W 154			

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W 154	<p>Continued From page 62</p> <p>Individual #92's nursing notes, dated 1/21/06 at 2:55 p.m., documented the RN/AOD assessed her and noted the following: "[Individual #92] is in bed she is awake, alert, cooperative. Her lungs are clear right. The left has rales in the base. Heart rate irregular with pulse deficit. Pulse oximetry difficult due to HR. [Individual #92] is breathing rapidly with accessory muscle in use. She is pale and lips slightly cyanotic. Contact MD - done orders received. [Individual #92] transported to [hospital] at 1520 (3:20 p.m.)."</p> <p>Individual #92's Physician's Orders, dated 1/21/06 at 3:00 p.m. showed the following: "Send to [hospital ER] for evaluation for Hypoxia and dehydration."</p> <p>Individual #92's nursing notes, dated 1/21/06 at 11:30 p.m., documented the hospital called and "notification that [Individual #92] expired approximately 30 minutes ago."</p> <p>Under the section titled Summary of Investigation, it documented the following: After the RN/AOD assessed [Individual #92] and talking to the doctor, the RN/AOD requested she be transported to the hospital for treatment by van and only with direct care staff to assist. "The LPN's working the unit felt this was a neglectful choice saying she should have been transferred by ambulance and administered oxygen." There were also allegations of inappropriate comments made while in her presence.</p> <p>Under the section titled Narrative, it stated the doctor was interviewed and he stated he presumed 911 would be called and she would be taken to the hospital by ambulance and that</p>	W 154			

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W 154	<p>Continued From page 63</p> <p>oxygen should have been administered. The reporting RN was interviewed and "She indicated the nurses, herself, and the QMRP had devised a plan that if [Individual #92] became Hypoxic that she would be transported by ambulance."</p> <p>The investigation showed one direct care staff and a supervisor transported Individual #92 to the hospital. Both staff were interviewed. One of the staff "asked if they were going to transport her by ambulance and [the RN/AOD] told her no. She then asked if she could take 2 staff in case something happened. During transport she seemed to be ok except her tongue looked grayish black which scared me [staff's name] to death." The second staff stated " ...during the transport [Individual #92's] breathing was very shallow and tongue dark. She sat in the back and fanned [Individual #92] the entire time. [The staff person] indicated that [the RN/AOD] seemed to be very flippant and was not taking the matter as serious as everyone else."</p> <p>The investigation showed a third direct care staff person was interviewed and stated "she heard [Individual #92] scream and went to her room to see what was happening. [RN/AOD] and [LPN's name] the LPN were already present. [The LPN] asked her to swab [Individual #92's] tongue because they thought the ensure is what was causing her tongue to turn gray. [The RN/AOD] then made the comment "that's [Individual #92] that's the way she always looks."</p> <p>The investigation showed the RN/AOD was interviewed and he stated the doctor did not give him direct orders to send Individual #92 to the hospital by ambulance or administer oxygen. "In</p>	W 154			

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W 154	<p>Continued From page 64</p> <p>his opinion [the RN/AOD's] he did not feel she was in distress, did not feel she looked any different than she usually does, heart rate was okay ...He did not feel she was in a medical emergency at the time." The RN/AOD was asked about the allegation of making inappropriate comments "that's just [Individual #92]. She always looks that way." "He said he may in fact have said that but it was in a situation where I was trying to get people to calm down and get control of the situation."</p> <p>Under the section titled Analysis of Findings, it stated "There seemed to be mistake of presumption on the part of both the physician and the RN/AOD in this case. Based on the verbal assessment made to the physician by the RN/AOD the physician ordered [Individual #92] to be transported to the hospital. He did not clearly indicate how she was to be transported. Since the physician indicated she needs to be evaluated for Hypoxia the physician assumed 911 would be called and she would be transported be ambulance with oxygen. Because there was no direct order given and based on his professional nursing assessment, [RN/AOD] made the decision to have her transported by van."</p> <p>Under the section titled Conclusion, it stated "the investigators concluded that RL #25 was violated and that [Individual #92] was neglected in that in her medical condition, (Hypoxia) she should have been at least given oxygen before or during her being transported to the hospital based on the physicians note to be evaluated for hypoxia. [The RN/AOD's] judgment was different from what everyone else had expressed.</p>	W 154			

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W 154	<p>Continued From page 65</p> <p>When asked about the RN/AOD not assessing [Individual #92's] tongue, the lead investigator stated during an interview on 6/19/06 from 12:25 - 12:40 p.m., the RN/AOD was not asked about it. When asked about the delay between the time the problem was noticed at 2:20 p.m., the time her stats were taken at 2:35 p.m. by the LPN, and the time she was assessed at 2:55 p.m. by the RN/AOD, the lead investigator stated timeliness was not questioned. When asked about the delay between the time the doctor gave the order to send her the hospital at 3:00 p.m. and the time she left for the hospital according to the staff statement at 3:30 p.m., the lead investigator stated timeliness was not questioned. Further, it was not evident the RN/AOD was asked about the discrepancy between his nursing entry "Heart rate irregular with pulse deficit" and his statement that Individual #92's heart rate was okay. It was not evident he was asked about sending direct care staff versus nursing staff with Individual #92. It was not evident the RN/AOD was asked about Individual #92 not receiving oxygen.</p> <p>Attached to the investigation was an Administrative Review which stated "No harm came to the client as a result of this incident." It was unclear how the determination was made given the fact Individual #92 did not receive oxygen, medical care was delayed, and she was transported to a hospital by non-nursing personnel in a van instead of by ambulance. It was unclear whether or not appropriate medical intervention would have changed Individual #92's health outcome.</p> <p>2. According to the facility's policy for Reporting and Investigation of Potential Individual</p>	W 154			

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W 154	<p>Continued From page 66</p> <p>Abuse/Neglect from Staff and Other Non-Residents (RL #25), dated 1/18/05, neglect was defined as "the failure to provide goods and services (including supervision) necessary to avoid physical or psychological harm and/or in such a manner as to jeopardize the life, health and safety of the individual. Examples of neglect included "Failure to execute individual programs or facility practices with good faith effort ...Failure to appropriately explore the reasons for, or attempt to alleviate a client's complaints of pain or discomfort." Psychological abuse was defined as "humiliation, threats of punishment or deprivation of/to an individual whether or not there was intention to cause such. Since many of the individuals residing at [the facility] are unable or may be reluctant to communicate feelings of fear, humiliation, etc., it is assumed that any actions that would usually be seen as psychologically abusive by a member of the general public are also seen as abusive by individuals who reside at [the facility], regardless of the individual's functional ability or perceived ability to comprehend the nature of the incident."</p> <p>An Investigation Report Form, dated 5/5/06, stated it was reported that an LPN insisted on obtaining a urine sample from Individual #30 by catheterization on 5/2/06 at 5:15 a.m. Direct care staff felt pressured to physically restrain her for the procedure and at least one of the staff felt it was unnecessarily severe.</p> <p>Individual #30's Physician's Order, dated 5/1/06, showed "U/A -may use minicath" was ordered. Individual #30's nursing notes, dated 5/2/06 at 5:45 a.m. stated "Attempted mini-cath without success." A corresponding Behavior Reporting</p>	W 154			

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W 154	<p>Continued From page 67</p> <p>Form (BRF) stated Individual #30 was hitting and kicking. The BRF documented a "4 point restraint" was used for "attempted cath" from 5:25 - 5:29 a.m. Attached to the investigation were "Instructions for Actual Medical Procedures" for Individual #30 which stated she required the use of sedation prior to most physical examinations by a physician, invasive medical procedures, or new medical procedures due to "high level of anxiety and the complications of her respiratory status." The Instructions showed "No HIS" was to be used during medical procedures.</p> <p>Attached to the investigation was an e-mail, dated 5/2/06, from the supervisor to the RN which stated "We need help. Tuesday morning one of the staff and I tired to help the NOC LPN do a cath on [Individual #30]. It was absolutely horrible. Of course [Individual #30] fought every way she could. Who wouldn't when being assaulted in that way?...Please help us because I believe what we did this morning was abusive to [Individual #30] on lots of levels." Another e-mail, dated 5/6/06, from the supervisor to the RN stated " ...[the LPN] had us put [Individual #30] on her left side and try to hold her that way while she attempted to put the cath in. I know that is not the appropriate way to insert a cath and it was probably painful to [Individual #30] having the cath attempted that way. Third, I know [Individual #30] has been abused in the past and for us to approach her in that way seemed to me to be very wrong. Forth she is very old and fragile and I do not think that we should be physically restraining her unless it is an extreme emergency. And fifth she has breathing problems. I told [the LPN] that I felt we should stop and when we did [Individual #30] was</p>	W 154			

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W 154	<p>Continued From page 68</p> <p>breathing so hard she was wheezing[the LPN] said she would give her a breathing treatment but she left the room and went and did other things and [Individual #30] had not had a breathing treatment when I left at 6:00 a.m. When I filled out the restraint sheet I called it a 4 point restraint because I really did not know what else to call it. What we did was I sort of held [Individual #30] across her shoulder and her arms and [another staff] held her ankles.</p> <p>Under the section titled Narrative, it showed the supervisor was interviewed and stated they had always used a "hat" before to collect urine samples and she did not know why the nurse wanted to use a catheter. "The nurse tried to insert the catheter tube from the back with [Individual #30's] knees pulled up. [The supervisor] said this clearly can't be done successfully. [The supervisor] described the procedure by saying that they put [Individual #30] on her side and she [the supervisor] held her hands. [Another staff] held her feet. [Individual #30] pulled her hand loose and smacked [the LPN] in the face. [Individual #30] was struggling. [The supervisor] told [the LPN] they had to quit because [Individual #30] was breathing really hard, wheezing. [The LPN] had tried three times from behind to catheterize [Individual #30] and two more times while [Individual #30] was on her back. She said she would do a breathing treatment. She didn't before [the supervisor] left at 6:00 or a skin check either, as far as [the supervisor] knew. [The supervisor] was further concerned that there was no documentation about the catheterization failing that would warn other nurses away from attempting it.</p>			W 154			

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W 154	<p>Continued From page 69</p> <p>The Narrative section also showed two direct care staff were interviewed. One staff stated "[The LPN] said they needed to hold [Individual #30]. [The supervisor] was by her shoulders. [Another staff] was patting her head telling her it was okay. [The staff person being interviewed] was by her feet. [The LPN] tried twice, first with [Individual #30] on her side, then on her back ...[Individual #30] was mad. Her state of mind was trauma-disoriented; she was kicking. The second staff stated "[Individual #30] was screaming. [The staff person] was at her head wiping her hair trying to calm her down. The procedure lasted 5 - 7 minutes. Finally they said "let's stop." [The supervisor] was at her chest trying to block her arms. There were 3 - 4 attempts made with the catheter. [The staff person] said she would not call anything that was done with [Individual #30] an HIS method ... [the staff person] said she had worked with [Individual #30] quite a bit and she is normally easy to get along with. She's pretty easy going. [The staff person] had never heard her scream until this time. It couldn't have felt too good. [The staff person] thought it would have been painful."</p> <p>The investigation showed the LPN was interviewed and "She said she immediately attempted a catheterization to collect a urine sample from [Individual #30] because she thought a sterile procedure would be better than just a clean catch. This was because glucose had been found in her urine the day before. [The supervisor] and [the LPN] had talked about who would get what (blood draw vs. UA) and day shift would get the other. Then [Individual #30] did so well with the blood draw that she decided to go ahead with the UA. [The LPN] thought it probably</p>	W 154			

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W 154	<p>Continued From page 70</p> <p>wasn't a minute before she gave that up. She only attempted the catheterization one time. She started with [Individual #30] on her left side, but she couldn't get a good enough view. [Individual #30] kept turning ... [The LPN] stated she catheterized [Individual #30] once before in late December or early January. She didn't recall the need for catheterization on that occasion. [Individual #30] didn't struggle as much that time, but it took three staff. [Individual #30] was on her left side. One staff held her feet and knees, one held her hips, and one was at the top but [the LPN] couldn't see what she held. Since the catheterization wasn't successful this time, they ended up using the hat later. [Individual #30] got a skin check and she was uninjured. However, [the LPN] didn't think she had documented it.</p> <p>Individual #30's Nursing notes, dated 12/17/05 at 4:15 a.m., showed she was successfully catheterized. There was no other information regarding how many staff were involved, Individual #30's response to the procedure, and there was no record of restraint showing start and stop times for the procedure.</p> <p>Under the section titled Analysis of Findings, is stated "Since T-3 Reduce the Need for Restraint During Medical Procedures [Individual #30's training plan] doesn't permit the use of HIS during actual medical procedures, staff were errant in using them, but this in itself does not constitute abuse. By RL #25's definition, unauthorized use of restraint would have to be for "purposes of punishment" to be abusive. There is no indication that that was the case here ..." Under the section titled Conclusion, it stated the investigators concluded that abuse did not occur as defined in</p>	W 154			

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W 154	<p>Continued From page 71</p> <p>the facility's policy.</p> <p>When asked whether the LPN was asked about the breathing treatment after the attempted catheterization, the co-investigator stated on 6/21/06 at 3:30 p.m., yes, a breathing treatment was given. However, Individual #30's Nursing Notes, dated 5/2/06 did not contain documentation that a treatment was given. When asked if the 12/17/05 incident was investigated, the co-investigator stated it was not looked at during this investigation. The co-investigator stated they reviewed the files and no one had filed a complaint or made an allegation about the 12/17/05 incident. When asked about the conclusion and whether psychological abuse and/or neglect was considered, the co-investigator stated they discussed it and it was felt there was no abuse, neglect, or mistreatment that occurred; Individual #30 did not want to cooperate with this.</p> <p>3. An SER dated 2/25/06 at 8:40 p.m. stated Individual #25 was found with "bruising to clients left foot and toes while undressing client for shower. Bruise to base of 1st, 2nd, and 3rd toes, with some lighter bruising to top of foot. Bruising extends to inner aspect of the left foot and around to the bottom of the foot and toes. Bruising to top of toes dark purple. Bruising to inner aspect of foot and around to bottom of foot dark purple. Bruising to top of foot and bottom base of 2nd and 3rd toes a light blue." His nursing notes, dated 2/26/06, documented his 2nd toe was broken. Thirteen staff statements documented that no one noticed or knew how he obtained the bruise. When asked if he was able to dress independently, the QMRP stated during an</p>	W 154			

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W 154	<p>Continued From page 72</p> <p>interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., he required staff assistance to dress. When asked how it went unnoticed by staff, the QMRP stated staff were not questioned about that.</p> <p>4. An SER dated 2/3/06 at 9:00 p.m. stated Individual #59 was found with a "2 inch blue bruise" above his genital area. Staff statements documented that he had been on daily bus rides with the seatbelt fastened across his waist/lap area. When asked if staff were questioned about whether or not staff checked the seat belt for tightness, the QMRP stated during an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., no, staff were not questioned about the seatbelt.</p> <p>5. An SER dated 2/22/06 at 3:55 a.m. stated Individual #20 was found with a 3 centimeter purple and black bruise on his right ribs. Twelve staff statements documented that no one noticed or knew how he obtained the bruise. When asked if he was able to dress independently, the QMRP stated during an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., no. When asked if he could bathe independently, the QMRP stated no. When asked how it went unnoticed by staff, the QMRP stated staff were not questioned about that.</p> <p>The facility failed to ensure thorough investigations were conducted for significant incidents involving Individuals #20, 25, 30, 59, and 92.</p>			W 154			

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W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination of the status of 26 of 91 individuals (Individuals #4 - 25, #30, #57, #59 and #60) residing in the facility. That failure resulted in individuals not receiving the services and training required to meet their developmental and behavioral needs. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to W124 as it relates to the QMRP's failure to ensure the individuals' written informed consents included all necessary information. 2. Refer to W195 - Condition of Participation for Active Treatment Services and related standard level deficiencies as they relate to the QMRP's failure to ensure individuals were receiving active treatment services as required. 3. Refer to W289 and W295 as they relate to the QMRP's failure to ensure all intervention strategies were incorporated into the individuals' program plans. 4. Refer to W303 as it relates to the QMRP's failure to ensure an accurate record for the use of restraints, including 30 minute checks, was kept 5. Refer to W312 as it relates to the QMRP's failure to ensure behavior modifying drugs were 	W 159			

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W 159	Continued From page 74 used only as a comprehensive part of the individuals' PCPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed.	W 159			
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure active treatment services were provided to the individuals residing in the facility. This resulted in a lack of involvement in activities which addressed individuals' priority needs and a lack of opportunities to practice new or existing skills. The findings include: 1. Refer to W124 as it relates to the facility's failure to ensure sufficient information was provided to parents/guardians on which to base consent decisions. 2. Refer to W159 as it relates to the facility's failure to ensure the QMRP provided sufficient monitoring and coordination of the status of the individuals residing in the facility. 3. Refer to W196 as it relates to the facility's failure to ensure individuals were provided with a continuous active treatment program.	W 195			

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W 195	<p>Continued From page 75</p> <p>4. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified the individuals' behavioral status and needs.</p> <p>5. Refer to W227 as it relates to the facility's failure to ensure individuals' PCPs specified objectives to meet their needs.</p> <p>6. Refer to W234 as it relates to the facility's failure to ensure individuals' behavior plans included sufficient direction to staff.</p> <p>7. Refer to W237 as it relates to the facility's failure to ensure the individuals' program plans specified behavior data to be collected that was in a form and frequency sufficient to adequately assess the efficacy of the intervention strategies.</p> <p>8. Refer to W249 as it relates to the facility's failure to ensure individuals received training and services consistent with their PCPs.</p> <p>9. Refer to W250 as it relates to the facility's failure to ensure active treatment schedules were sufficiently developed to direct the staff.</p> <p>10. Refer to W252 as it relates to the facility's failure to ensure staff recorded behavioral data in the form and frequency specified in the program plan.</p> <p>11. Refer to W255 as it relates to the facility's failure to ensure individuals' objectives were revised as appropriate.</p> <p>12. Refer to W260 as it relates to the facility's failure to ensure the individuals' PCP information</p>	W 195			

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W 195	Continued From page 76 was updated as needed. 13. Refer to W262 as it relates to the facility's failure to ensure sufficient information was provided to HRC on which to base program recommendations/approvals.	W 195			
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure individuals received formal and informal training and opportunities consistent with their developmental needs for 6 of 18 individuals (Individuals #6 and 21 - 25) whose active treatment program was comprehensively reviewed. That failure resulted in individuals not receiving training and services necessary to promote independence and maximize their developmental potential. The findings include: 1. Individual #21's PCP, dated 1/18/06,	W 196			

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W 196	<p>Continued From page 77</p> <p>documented a 24 year old male diagnosed with profound mental retardation, intermittent explosive disorder, seizure disorder, cerebral palsy with spastic quadriplegia, and scoliosis of the spine. He used a wheelchair for ambulation and mobility.</p> <p>a. During an observation on 5/18/06 from 6:50 - 8:45 a.m. (1 hour 55 minutes), Individual #21 was noted to be engaged in the following activities: 7:43 - 8:00 a.m.: He came out of his bedroom room to living area. Present staff stated he liked to sit in the sun in the morning. At 7:46 a.m., a staff applied sunscreen on him and then wheeled him outside. 8:00 - 8:30 a.m.: He returned inside and was sitting in his wheelchair, leaned forward and to his right side, and his head was on his lap tray. At 8:10 a.m., a staff positioned his wheelchair at the dining table. He remained in the same forward position with his head on the lap tray as the staff wiped the table. 8:30 - 8:45 a.m.: He was fed breakfast by staff. When asked, present staff stated he had an objective to only hold a spoon for 5 seconds.</p> <p>Individual #21 was not observed to participate in skill-building or meaningful activity during the observation. He did sit in the morning sun for approximately 10 minutes.</p> <p>b. During an observation on 5/19/06 from 10:25 - 11:40 a.m. (1 hour 15 minutes), Individual #21 was noted to be engaged in the following activities: 10:25 - 10:30 a.m.: He sat in his wheelchair waiting to leave the unit. 10:30 - 10:36 a.m.: He was transported via his</p>	W 196			

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W 196	<p>Continued From page 78</p> <p>wheelchair to the vocational building. 10:36 - 10:40 a.m.: He arrived at the classroom. He sat in his wheelchair, leaning forward and to his right side, and his head was on his lap tray. 10:40 - 10:49 a.m.: A staff person removed the lap tray from the wheelchair. He leaned forward and to his right side and then rested his head on the armrest of the wheelchair. The staff person talked with him for no more than a minute to which he did not respond. 10:49 - 10:51 a.m.: A staff prompted him to wake up and go crush cans. The staff person attempted to get him to hold a soda can. He did not respond. The staff put the soda can on the floor and asked him to un-cross his feet which he did. Staff asked him to kick the can and he did not respond. He put his head back on the right armrest of his wheelchair. 10:55 - 11:00 a.m.: A second staff person asked him a question and he did not respond. The staff person picked up the soda can from the floor and set it on a nearby counter. The staff walked away. 11:00 - 11:02 a.m.: The first staff person obtained another soda can and assisted him to feel it as the staff said "crush can". The staff person propped him up and he did not respond. The staff person placed the soda can on the floor as he put his head back on the armrest of his wheelchair. The staff informed him he would return in a few minutes. 11:02 - 11:06 a.m.: The staff prompted him to wake up again and had him feel the can. He did not respond. Staff propped him up again but he continued to lean to his right side. The staff person walked away. He crossed his feet, leaned forward and to his right side, and put his head on the armrest. 11:06 - 11:10 a.m.: A second staff asked him a</p>	W 196			

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W 196	<p>Continued From page 79</p> <p>question and he did not respond. The staff walked away.</p> <p>11:10 - 11:15 a.m.: A staff asked him if he wanted a drink before lying down. He did not respond. Staff repeated the question, and again, he did not respond. At 11:13 a.m., staff called him by name and he did not respond but continued to sit in a forward and right position with his head on his armrest.</p> <p>11:15 - 11:20 a.m.: The supervisor, who was present, talked with him. The staff person put his helmet on him and then the supervisor and the staff used a Hoyer lift and transferred him to a nearby changing table.</p> <p>11:20 - 11:28 a.m.: He was lying on the padded changing table. He rolled to his left side and there was a notable red mark on his upper right arm from the armrest of his wheelchair. The staff closed the curtain around him and proceeded to change his Attends (adult diaper).</p> <p>11:28 - 11:40 a.m.: The staff person pulled back the curtain and it was noted that he was covered with a sheet and was still wearing the helmet. When asked, present staff stated he wore the helmet when he was in bed because he hit his head. The staff person stated he would now sleep for a good half hour or so. He was lying on the changing table when the observation ended at 11:40 a.m.</p> <p>Individual #21 was not observed to participate in skill-building or meaningful activity during the observation; staff talked with him approximately 11 minutes.</p> <p>c. During an observation on 5/19/06 from 4:00 - 6:10 p.m. (2 hours 10 minutes), Individual #21 was noted to be engaged in the following</p>	W 196			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2006
NAME OF PROVIDER OR SUPPLIER IDAHO STATE SCHOOL AND HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ELEVENTH AVE NORTH NAMPA, ID 83686		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	<p>Continued From page 80</p> <p>activities: 4:33 - 4:44 p.m.: He arrived on the unit at 4:33 p.m. A staff person removed his lap tray and footrests from his wheelchair. He sat in his wheelchair and verbalized unintelligible noises. 4:44 - 4:57 p.m.: A staff person talked to him for no more than thirty seconds and then left the area. At 4:45 p.m., he was taken to the kitchen to "help" get dishes set up for dinner. He was noted to sit and watch a staff prepare individuals' table settings. Periodically, he kicked a cabinet and staff repositioned his wheelchair. 4:57 - 5:15 p.m.: A staff person put the lap tray back on his wheelchair. At 5:00 p.m., the staff person placed individuals' table setting on the lap tray, transported him and the dishes via the wheelchair to a cabinet in the dining room, and put the dishes in the cabinet. He and the staff returned to the kitchen where the staff prepared additional table settings for individuals, placed the table setting on the lap tray, transported him and the dishes via the wheelchair to a cabinet in the dining room, and put the dishes in the cabinet. He was noted to be leaning to his right side in the wheelchair. 5:15 - 5:35 p.m.: He sat in his wheelchair which had been positioned near the dining room table. 5:35 - 6:10 p.m.: He was fed his dinner meal by staff. At 5:50 p.m., he was noted to put his left hand down the front of his pants twice. Staff redirected his hand then continued to feed him. When asked, present staff stated he only had an objective to hold a spoon for five seconds.</p> <p>Individual #21 was not observed to participate in skill-building or meaningful activity during the observation.</p>	W 196			

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W 196	<p>Continued From page 81</p> <p>d. During an observation on 5/20/06 from 1:30 - 2:30 p.m. (1 hour), Individual #21 was noted to be engaged in the following activities:</p> <p>1:30 - 1:45 p.m.: He was being fed by staff. He was noted to have red marks and scratches on his forehead, left cheek, and under his entire chin. When asked, present staff stated it was from his helmet - he attempted to remove the helmet by grasping the chin strap (without releasing it) and pulling it over his head. When asked why he had the helmet on, the staff person stated he had been lying down.</p> <p>1:45 - 1:50 p.m.: He was in his wheelchair which was positioned by front desk.</p> <p>1:50 - 1:59 p.m.: The supervisor, who was present, took him to the nurse.</p> <p>1:59 - 2:03 p.m.: He returned from the nurse and was positioned in front of the patio door which was open.</p> <p>2:03 - 2:22 p.m.: A staff person placed two small bean bags on his right leg (above his knee). By 2:05 p.m., the bean bags had fallen on the floor. He sat in his wheelchair leaning to his right side and with his head down. At 2:13 p.m., a staff talked with him for approximately 10 seconds and then left the area. At 2:18 p.m., a staff talked with him for approximately 10 seconds and then left the area. He continued to sit in his wheelchair leaning to his right side and with his head down.</p> <p>2:22 - 2:30 p.m.: A staff took him outside to the patio and at 2:23 p.m., the staff person brought him back in and then left the area. He sat in the living area. At 2:27 p.m., a staff talked with him for approximately 10 seconds and then left the area. He continued to sit in the living area when the observation ended.</p> <p>Individual #21 was not observed to participate in</p>			W 196			

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W 196	<p>Continued From page 82</p> <p>skill-building or meaningful activity during the observation.</p> <p>During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were not to feed Individual #21 and staff were to follow the scenario books and activity schedules.</p> <p>2. Individual #22's PCP, dated 11/2/05, documented a 57 year old female diagnosed with severe mental retardation, organic brain syndrome, seizure disorder, and dementia NOS (not otherwise specified).</p> <p>a. During an observation on 5/18/06 from 6:50 - 8:45 a.m. (1 hour 55 minutes), Individual #22 was noted to be engaged in the following activities: 7:17 - 7:30 a.m.: She laid down on the living room couch. 7:30 - 7:35 a.m.: She took her medications. 7:35 - 7:43 a.m.: She laid back down on the living room couch. Present staff stated she had dementia and was retired. 7:43 - 8:10 a.m.: A staff person tried to engage her by rubbing beads on her arm for no longer than two minutes and by 8:08 a.m., she was sleeping. 8:10 - 8:45 a.m.: The supervisor, who was present, talked with her for no more than two minutes. She remained on the couch and put a hat over her eyes. She remained in that position until the observation ended at 8:45 a.m.</p> <p>With the exception of taking her medications (5 minutes) and staff talking and trying to engage her (4 minutes), Individual #22 was not engaged in skill-building or meaningful activity during the observation.</p>	W 196			

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W 196	<p>Continued From page 83</p> <p>b. During an observation on 5/19/06 from 4:00 - 6:10 p.m. (2 hours 10 minutes), Individual #22 was noted to be engaged in the following activities:</p> <p>4:00 - 4:13 p.m.: She stood by the door of the unit and a staff person was noted to be standing nearby. The staff person asked her if she wanted to go outside. She responded by yelling and then hit her head on the wall. A staff person gave her a hat and used physical assistance to put it on her. She remained at the door and periodically, she screamed.</p> <p>4:13 - 4:15 p.m.: A staff showed her, her reflection, and then held up a hand mirror. She looked at herself and staff prompted her to go sit down. She did not respond.</p> <p>4:15 - 4:19 p.m.: She laid down on the living room couch.</p> <p>4:19 - 4:40 p.m.: She stood up, and with physical assistance, she was guided to the outside patio area. She walked from the patio to an area that contained a lounge and no grass. There was a piece of carpet on the ground which was covered with dirt. She proceeded to sit on the dirt-covered carpet and then laid down on it. A staff person arrived and she sat up. The staff person applied sunscreen to her arms, face, and neck, and then left the area. Periodically, she sat up, ran her fingers through the dirt, and then laid down again. When asked, present staff stated periodically, she would sit on the lounge; usually she would seek out areas with no grass and she liked to sit in the dirt.</p> <p>4:40 - 4:45 p.m.: She came back inside the unit with verbal prompting and was accompanied to her bedroom by a staff to clean up.</p> <p>4:45 - 4:50 p.m.: She came out of her bedroom</p>	W 196			

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W 196	<p>Continued From page 84</p> <p>with clean clothes on. She proceeded to walk over and stand by the unit door. A staff person assisted her to put on a wig. 4:50 - 4:55 p.m.: She sat at the dining table. 4:55 - 4:57 p.m.: She stood up and walked over to the surveyor. She held her breath, let it go, and started to fall. A staff person assisted her to the floor and in to a sitting position. The staff commented that she thought it was seizure-like activity. She sat for approximately one minute then stood up with physical assistance from the staff person. She and the staff person walked around the unit into the television room where she sat down. 4:57 - 5:15 p.m.: She was watching television. 5:15 - 5:35 p.m.: She got up, washed her hands with staff assistance, and sat at the dining table. 5:35 - 6:10 p.m.: She picked up her glass of milk and quickly drank the entire glass without stopping. Milk was noted to run down the corners of her mouth. Staff were not noted to prompt her to slow down or intervene. She then ate her dinner meal.</p> <p>With the exception of eating, Individual #22 was engaged in skill-building or meaningful activity for no more than 25 minutes during the observation.</p> <p>c. During an observation on 5/20/06 from 1:30 - 2:30 p.m. (1 hour), Individual #22 was noted to be engaged in the following activities: 1:30 - 1:35 p.m.: She was sitting with her legs up on the couch. 1:35 - 1:45 p.m.: A staff assisted her to put a wig on then had her look at herself in a hand-mirror. The staff person wrapped a green scarf around the top of the wig. The staff then put a hat on top of the wig and handed her a string of beads. She</p>	W 196			

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W 196	Continued From page 85 reached down and obtained additional beads from a plastic box on the floor, held them for no more than one minute, and then put them back in the box. 1:45 - 1:50 p.m.: She removed the hat/scarf/wig combination, dropped it on the floor, and proceeded to lie down on the couch. 1:50 - 1:55 p.m.: A staff held the hand mirror such that she could see her reflection. She reached for it and staff reached in to her nearby box (on the floor) and offered her the wig and scarf. She did not respond. At 1:53 p.m., the staff prompted her to sit up. She did not respond but continued to lie on the couch. Staff offered her the mirror again and she pushed it away. Within 30 seconds, she sat up and the staff put the wig on her and handed her the mirror. She took the mirror and threw it on the floor. 1:55 - 2:00 p.m.: She sat with her legs up on the couch. 2:00 - 2:30 p.m.: She laid down on the couch. At 2:04 p.m., a staff person talked with her for no more than 15 seconds and left the area. She continued to lie on the couch. At 2:18 p.m., a staff talked with her for approximately 10 seconds and then left the area. She continued to lie on the couch. At 2:22 p.m., a staff talked with her for approximately 10 seconds and then left the area. She continued to lie on the couch. At 2:27 p.m., she repositioned herself on the couch such that she was on her hands and knees. A staff talked with her for approximately 5 seconds and then left the area. She repositioned herself again and laid on her left side on the couch. At 2:29 p.m., a staff prompted her to get up and go get her medications. She had not responded when the observation ended at 2:30 p.m.	W 196			

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W 196	<p>Continued From page 86</p> <p>Individual #22 was not observed to participate in skill-building or meaningful activity during the observation.</p> <p>During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were to follow the scenario books and activity schedules.</p> <p>3. Individual #6's PCP, dated 2/15/06, documented a 52 year old male diagnosed with profound mental retardation, pervasive developmental disorder, autism, and OCD.</p> <p>a. During an observation on 5/18/06 from 6:50 - 8:45 a.m. (1 hour 55 minutes), Individual #6 was noted to be engaged in the following activities: 7:21 - 7:23 a.m.: He took his laundry to the laundry room with staff assistance. 7:23 - 7:30 a.m.: He took his medications with staff assistance. 7:30 - 8:22 a.m.: He sat at a dining table and independently put together large-piece puzzles. 8:22 - 8:35 a.m.: He ate breakfast. 8:33 - 8:45 a.m.: He was sitting at the table when the observation ended at 8:45 a.m.</p> <p>With the exception of eating, Individual #6 was engaged in skill building activity for no more than 9 minutes during the observation.</p> <p>b. During an observation on 5/19/06 from 4:00 - 6:10 p.m. (2 hours 10 minutes), Individual #6 was noted to be engaged in the following activities: 4:33 - 4:44 p.m.: He arrived on the unit at 4:33 p.m. At 4:35 p.m., a staff person offered him a large-piece puzzle which he carried to the table. He sat down and proceeded to independently put the puzzle together.</p>	W 196			

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W 196	<p>Continued From page 87</p> <p>4:44 - 4:45 p.m.: He stood up and walked towards his bedroom. A staff asked him if he wanted to run his "housekeeping" program. He and the staff person went in to his bedroom and shut the door.</p> <p>4:45 - 5:05 p.m.: He came out of his room and walked back to the table containing his puzzle. A staff proceeded to take the puzzle apart and put the pieces in its box. He put the puzzle away and returned to the table with another puzzle.</p> <p>5:05 - 5:20 p.m.: He wiped the table with verbal prompting, put the dishcloth in a nearby laundry bin, and sat at the dining table.</p> <p>5:20 - 5:26 p.m.: He went to his bedroom with a staff and promptly returned to the table and sat down.</p> <p>5:26 - 5:35 p.m.: He washed his hands at the kitchen sink and returned to the dining table and sat down. At 5:30 p.m., he was prompted by staff to get his table setting which he did and returned and sat at the table.</p> <p>5:35 - 6:05 p.m.: A staff person put mustard and catsup on two slices of bread and added ground turkey to make a sandwich. The staff cut the sandwich into bite-size pieces and placed a serving of potatoes and a serving broccoli on the plate. The staff cut the potatoes and broccoli in smaller pieces and gave the plate to him. He ate his dinner meal.</p> <p>6:05 - 6:10 p.m.: He sat at the table, holding a spoon.</p> <p>With the exception of eating, Individual #6 was engaged in skill building activity for no more than 5 minutes during the observation.</p> <p>c. During an observation on 5/20/06 from 1:30 - 2:30 p.m. (1 hour), Individual #6 was noted to be</p>	W 196			

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W 196	<p>Continued From page 88</p> <p>engaged in the following activities: 1:30 - 1:35 p.m.: He was standing in the front dining area watching others. 1:35 - 2:15 p.m.: A staff person put a large-piece puzzle on the table. He sat at the table and put the puzzle together. At 2:13 p.m., a staff asked him if he was having trouble with the puzzle and assisted him for approximately 15 seconds and then left the area. He finished the puzzle at 2:15 p.m. 2:15 - 2:25 p.m.: He was redirected to his bedroom by a staff person. 2:25 - 2:28 p.m.: A staff went to check on him and he came out of his bedroom. The staff person redirected him back to his bedroom to change his shirt. 2:28 - 2:30 p.m.: He came out of his room wearing a clean shirt and carrying the soiled one. He took the soiled shirt to the laundry room. He came out of the laundry room and returned to the table where staff assisted him to disassemble the puzzle and put it away.</p> <p>Individual #6 was engaged in skill building activity for no more than 15 minutes during the observation.</p> <p>During an interview on 6/15/06 from 9:00 a.m. - 1:00 p.m., the QMRP stated staff were to follow the scenario books and activity schedules.</p> <p>4. Individual #25's PCP, dated 8/17/05, documented a 41 year old male diagnosed with profound mental retardation, major depression, organic brain syndrome, Type 2 diabetes, and he was legally blind and deaf.</p> <p>a. During an observation on 5/19/06 from 4:00 -</p>	W 196			

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W 196	<p>Continued From page 89</p> <p>6:10 p.m. (2 hours 10 minutes), Individual #25 was noted to be engaged in the following activities: 4:33 - 4:40 p.m.: He arrived on the unit at 4:33 p.m. A staff person took him to the bathroom. 4:40 - 5:19 p.m.: He sat in his recliner which was located in his bedroom and his head was down. A staff assisted him to put on his headphones and then left his room. 5:19 - 5:26 p.m.: He was physically assisted out of his room to the dining room where he washed his hands with hand-over-hand assistance, obtained his place setting from a nearby cupboard, and sat at the table. 5:26 - 5:35 p.m.: He sat at the table and drank a glass of juice. 5:35 - 5:55 p.m.: He ate dinner. 5:55 - 6:10 p.m.: He sat in a recliner in the living area with a tube-shaped massager around his neck.</p> <p>With the exception of using the bathroom and eating, Individual #25 was engaged in skill building activity for no more than 7 minutes during the observation.</p> <p>b. During an observation on 5/20/06 from 1:30 - 2:30 p.m. (1 hour), Individual #25 was noted to be engaged in the following activities: 1:45 - 2:18 p.m.: He sat in his recliner which was located in his bedroom and his head was down. He was wearing his headphones and rocking back and forth in the recliner. 2:18 - 2:30 p.m.: A staff person walked into and out of his bedroom. He continued to sit in his recliner with his head down when the observation ended. When asked, a direct care staff staff stated he liked to listen to his headphones.</p>	W 196			